

3D-treatment plan with DVHs for CTV and lung was obtained. Twenty-three pts had chemo and 14 hormone therapy. Pre-RT workup included HRCT and lung function tests. HRCT was performed by spiral CT with contiguous slices, 10 mm interval, 1 mm thickness from apex to diaphragm. Lung changes were scored 0-3. Lung function tests were: forced vital capacity (FVC), forced expiratory volume in 1 second (FEV-1), total lung capacity (TLC), forced expiratory flow at 25% of vital capacity (FEF-25) and diffusion capacity (DLCO). Plethysmography with constant volume was used. Tests were repeated 3 and 9 months after RT in 41/45 pts. HRCT slices were matched with RT-plan images.

**Results:** Pre-RT HRCT did not show any lung abnormality. Three months after RT, HRCT showed fibrosis in RT volume in 31/41 cases (76%): 44% grade I, 25% grade II, 7% grade III. At 9 months, fibrosis was seen in 32/41 pts (78%): 59% grade I, 19% grade II, 0% grade III. None developed clinical symptoms. Grade of fibrosis at 3 and 9 months correlated with RT volume ( $p=0.0096$  and  $0.0003$  respectively). Changes at 3 and 9 months correlated to the dose of 25 Gy to volume  $\geq 107$  cm<sup>3</sup> and 151 cm<sup>3</sup> respectively. Pre-RT lung function tests were normal. All values decreased at 3 months: FVC and FEV-1 without and FEF-25 and DLCO with significance ( $p=0.029$  and  $p=0.0006$ ). At 9 months, FVC and FEV-1 showed recovery and FEF-25 and DLCO remained abnormal ( $p=0.026$  and  $0.0001$  respectively).

**Conclusion:** This study confirms that RT does not induce clinically relevant lung injuries. HRCT and functional tests are able to detect subclinical changes: subpleural fibrosis and reduction of functioning of bronchiole (FEF-25) and alveolar/capillary membrane (DLCO). Fibrosis correlates with volume receiving  $> 25$  Gy. Age, smoke, chemotherapy, and hormone therapy were not prognostic factors.

923

POSTER

#### Clinical outcomes of palliative interventions for bowel obstructions in patients suffering from peritoneal carcinomatosis from non-gynecological cancer

E. Thanopoulou<sup>1</sup>, A. Stamatelopoulou<sup>2</sup>, G. Karavitis<sup>3</sup>, G. Lazaridis<sup>4</sup>, N. Sarantzis<sup>4</sup>, K. Vlachos<sup>5</sup>, D. Vassilakos<sup>6</sup>, M. Arnaouti<sup>7</sup>, G. Economou<sup>2</sup>.  
<sup>1</sup> Athinaion B, Medical Oncology, Athens, Greece; <sup>2</sup> S. Sabbas, Surgical Oncology, Athens, Greece; <sup>3</sup> 492 Gen. Mil. Hospital, General Surgery, Alexandroupoli, Greece; <sup>4</sup> AHEPA Hospital, 1st Univ. General Surgery, Thessaloniki, Greece; <sup>5</sup> Dist. Reg. Hospital, General Surgery, Samos, Greece; <sup>6</sup> AHEPA Hospital, Anesthesiology, Thessaloniki, Greece; <sup>7</sup> S. Sabbas, Histopathology lab., Athens, Greece

**Background:** The main aim of our study was to evaluate the clinicopathologic factors that predict outcomes after palliative operations for malignant bowel obstruction (MBO). This situation secondary to peritoneal carcinomatosis carries a poor prognosis.

**Material and Methods:** From four different surgical centers, data on patients undergoing laparotomy for palliation of gastrointestinal MBO, between 1998 and 2002 were retrospectively collected. As successful palliation was defined the ability to tolerate solid food. (TSF).

**Results:** 178 patients underwent operative treatment. In 57 pts, MBO was the first presentation of the disease; for the others, the median disease-free interval was 16 months. The complication rate was about 42.5% and the postoperative mortality was 16%. The median length of stay was 14 days. 79 pts (44.8%) were discharged from the hospital on a regular diet. 137 pts (76.6%) continued to eat until their last follow-up. Median survival was 90 days. Univariate factors for longer survival were TSF on discharge, colorectal primary and non-metastatic status at first diagnosis. Patients with ascites and whose cancer first presented with MBO had an inferior survival. Non colorectal primary remained a multivariate predictor for decreased survival. TSF was predicted by the absence of ascites, an obstruction not involving the small bowel, and a preoperative albumine of  $>3.0$ mg/dl. Multiple logistic regression analysis yielded presence of ascites and small bowel obstruction as predictors of inability to TSF.

**Conclusions:** Only 35.8% of the patients with MBO from peritoneal carcinomatosis will have prolonged post-operative palliation with significant treatment-related morbidity. TSF at discharge is a useful predictor of continued palliation for most pts. Patients with colorectal cancer may have superior outcome and better palliation; others are at risk for poor outcomes, especially in the presence of ascites and MBO of small bowel. In these pts. is recommended a highly selective use of laparotomy.

924

POSTER

#### A pilot study of influences on decisions to receive chemotherapy in patients with advanced cancer

G.C. Higgins, A. Price. University of Edinburgh, Oncology, Edinburgh, United Kingdom

**Background:** Previous studies have suggested that patients with advanced cancer may find existing survival benefits from chemotherapy inadequate to justify treatment. We wished to test this, and explore contributory factors. Aim To determine what survival advantage justified chemotherapy for patients with advanced cancer and explore influences on decision making.

**Methods:** Patients with advanced cancer were identified in routine follow-up clinics, and given 4 scenarios describing patients with cancer and expected survival of 4 or 12 months (chosen to approximate the survival without chemotherapy of patients with advanced lung or breast cancer) who were offered either low toxicity outpatient or high toxicity inpatient chemotherapy. They were asked to score on a visual analogue scale (range 0-22 months) what survival benefit they would wish to receive from chemotherapy in each situation, score their quality of life, complete the Beck Hopelessness questionnaire and scored for deprivation category using the Carstairs index.

**Results:** 31 patients (18 with lung and 13 breast cancer; 12 male, 19 female, median age 64 (range 42-77) years) were given the scenarios. The median survival benefit to justify chemotherapy in each scenario for patients with lung and breast cancer were 7.6 (range 0.1-21.5) and 1.5 (0.4-12.3) months (Mann-Whitney U = 64,  $p=0.04$ ); 9.7 (0.1-21.6) and 6.0 (0.1-19.5) months ( $p=0.25$ ); 9.3 (0.2-21.7) and 4.0 (0.3-19.4) months ( $p=0.1$ ); and 10.3 (0.1-21.8) and 6.0 (0.1-21.5) months ( $p=0.13$ ). No significant correlation was seen with any factor other than prior experience of chemotherapy. Two way ANOVA of the survival benefits desired showed significant differences between scenarios ( $p=0.0003$ ) and between patients ( $p<0.0001$ ). For lung cancer patients 95% of the total variation was patient-related and  $<1\%$  due to the scenarios, while for patients with breast cancer this was 69% and 7%.

**Conclusion:** For most patients the survival benefit justifying chemotherapy exceeded that provided by current regimes. However there were wide differences between patients. These were not explained by the factors analysed but were predominantly inter-patient variations independent of clinical scenarios. The criteria for wanting chemotherapy differed between patients with lung and breast cancer.

925

POSTER

#### An examination into the cultural validity and reliability of the Turkish version of EORTC QLQ-C30

A. Guzelant<sup>1</sup>, T. Goksel<sup>2</sup>, S. Ozkok<sup>3</sup>, S. Tasbakan<sup>2</sup>, T. Aysan<sup>2</sup>, A. Bottomley<sup>4</sup>. <sup>1</sup> Izmir-Konak District Health Directorate, Izmir, Turkey; <sup>2</sup> Ege University Medical School, Department of Chest Diseases, Bornova - Izmir, Turkey; <sup>3</sup> Ege University Medical School, Department of Radiation Oncology, Bornova - Izmir, Turkey; <sup>4</sup> EORTC, Quality of Life Unit, Brussels, Belgium

The assessment of quality of life has become an increasing important aspect to evaluate in cancer clinical trials. One of the most commonly used measures to do this is the European Organization for Treatment and Research of Cancer Quality of Life Questionnaire (EORTC QLQ-C30). While this has been translated into over 48 languages, including Turkish, no large scale cultural psychometric validation of the Turkish translation has been published. We therefore undertook a study to provide evidence of validity and reliability. In a cross sectional study, lung cancer patients were recruited between January and March 2000. All patients were treated and followed in the Departments of Chest Diseases and Radiation Oncology (Izmir/Turkey) were asked to complete the EORTC QLQ-C30. KPS was used to assess the functional status. Patients completed the EORTC QLQ-C30 on the same day with an assessment of the performance status. Two hundred and two patients completed the measure. The mean age was 57.9. When EORTC QLQ-C30 scales were completed, 54.6% of the patients were receiving chemotherapy, 23.2% radiotherapy, and 16% palliative treatments. Psychometric analysis revealed the percentage of missing items were generally low ( $<1.5\%$ ) with the exception of the items related with the global health status (item no 30 and 31, 3.6% missing), financial difficulties (no 28, 3.6% missing) and emotional functioning (no 24, 2.6% missing). All the subscales met the minimal standards of reliability (Cronbach's alpha 0.70). Only role functioning scale differed among the three disease stages of patients (local, locoregional, and metastatic). All interscale correlations were statistically significant ( $p<0.01$ ). The strongest correlations were found among physical functioning, role functioning, and