Results: The 26% of Littlewood HM pts who met NOW criteria experienced substantially better outcomes than those who did not. Table 1 compares the results of NOW-eligible and NOW-ineligible Littlewood HM pts.

Table 1.

	NOW-ineligible Littlewood HM pts n=124	NOW-eligible Littlewood HM pts n=43	Outcomes difference
Change in Hb during study	2.0 g/dL	2.6 g/dL	30%
TF required	44 (35.5%)	6 (14.0%)	254%

NOW pts receiving epoetin beta 30,000 IU QW experienced a 2.0-g/dL change in Hb (Cazzola 2002), 0.6 g/dL less than the NOW-eligible patients from the Littlewoood HM cohort.

Conclusions: The application of NOW exclusion criteria selects for significantly improved patient outcomes. These results suggest that HM pts who do not meet NOW criteria may have a lesser response to rHuEPO dosed at 30,000 IU QW. This regimen should be used with caution in a carefully selected subset of patients. Further studies should establish an optimal weekly rHuEPO dosing regimen for anemia correction in a broad range of HMs.

943 POSTER

Early administration of hemoglobin-adapted doses of erythropoietin with intravenous iron for the prevention of chemotherapy-induced anemia

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Background: Treatment of chemotherapy (CT)-induced anemia requires high doses of erythropoietin (EPO) and time to response usually takes 4 weeks (w). A functional iron deficiency due to underlying cancer prevents a quick and full response to EPO. We tested the feasibility of an early administration of EPO (Eprex ®) given with intravenous (iv) iron (Venofer ®) for the prevention of anemia.

Patients and methods: Chemonaïve, non-anemic (hemoglobin (Hb) > 11 g/dL) patients (pts), due to receive at least 3 cycles of a platinum-based CT were included. Subcutaneous EPO 10'000 U three times a week (3x/w) and iv iron 100 mg once a week were initiated as soon as Hb declined under 13 g/dL. EPO dose was adjusted according to Hb every 4 w. If Hb was stable (11-13 g/dL), the EPO dose was reduced to 4000 U 3x/w, and 4 w later to 2000 U 3x/w. If Hb was >13 g/dL, EPO was withheld and for values <11 g/dL, EPO was increased to 20'000 U 3x/w. EPO and iv iron were stopped at the end of chemotherapy or in the case of EPO resistance (Hb<11 g/dL after 4 w of EPO at 20000 U 3x/w).

Results: 37 pts have been included: male/female (26/11); PS ≤1/2 (34/3); median age 58 years (36-69); lung/other cancer (28/9); cisplatin/carboplatine-CT (33/4). Of 37 pts, 2 pts never received EPO (1 pt had a CT related hemolysis at day 15; 1 pt was non-compliant) and 2 pts had EPO interruption for safety reasons (myocardial infarction at day 16 with Hb=14.6; transient cerebral ischemia at day 7 with Hb=12) and were excluded from the efficacy analysis. For the 33 evaluable patients, the median number of CT cycles was 4 (1-6). The median duration of CT treatment was 13 w (5-20) and the median duration on EPO treatment was 8 w (0-20). EPO was withheld in 40% of the treatment time, because of Hb>13 g/dL. Decrease from 10000 dose level to 4000 and 2000 was realized in 33% and 21% of the pts, respectively. Increase to 20000 was necessary in 9 pts (27%) and EPO resistance was seen in 7 pts (23%). The mean EPO dose required per pt was 5678 U 3x/w. Mean Hb level was 13.4 ±1.5 g/dL at the start of CT and 10.8 ±1.8 g/dL at the end of CT. At the end of CT, Hb>11 g/dL was achieved in 18/33 pts (55%). NCI-CTC grade 2 anemia (Hb<10 g/dL) was prevented in 24/33 pts (72%) and only 3 pts required blood transfusions. No side-effects occurred with iv iron administration.

Conclusions: This monthly, hemoglobin-adapted, dose-reducing EPO regimen with iv iron allowed a 43% reduction of the standard starting dose (10'000 U 3x/w in pts Hb<10.5). Prevention of NCI-CTC grade 2 anemia (Hb<10 g/dL) was achieved in 73% of the patients. Early use of EPO with iv iron in the prevention of chemotherapy-induced anemia is a promising supportive treatment that should be compared to the standard practice of beginning EPO later in cancer patients once anemia has already occurred.

First and second authors contributed equally to the work.

Eprex ® was supplied by Janssen-Cilag CH and Venofer ® by Vifor CH.

944 POSTER

Does selective gut decontamination in oncology patients reduce the number of bacteraemia's?

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Introduction: Infectious complications remain a source of morbidity and mortality in oncology patients. Selective decontamination of the digestive tract (SDD) was introduced in the 70's by administration of oral partly absorbable and partly non-absorbable antibiotics, often in combination with anti-fungal prophylaxis to reduce infections. Despite the amount of studies involving SDD, there is still no consensus whether SDD should be given and what antibiotic to use. In this systematic review we will assess the efficacy of TMS, fluoroquinolones and fluoroquinolones plus an antibiotic covering gram positive infections.

Objectives: To identify all randomized controlled trials evaluating the reduction of bacterial infections by SDD in oncology patients (both adults and children) who are receiving chemotherapy with expected neutropenia.The main outcome is documented bacteraemia during episodes of using SDD.

Search strategy: We performed a computer-assisted search using Medline from 1966 to October 2002, Embase 1966-2002 and the Cochrane Database.The computer search was supplemented by checking the references of these articles for additional papers.

Data collection & analysis: The studies identified were assessed and the data extracted independently by the two reviewers and a quality assessment was carried out using a quality list (Tulder).

Results: 59 articles were included of which only 18 articles fullfilled the strict criteria of metholodogical quality. Analyzing the results comparing studies using SDD to placebo favoured treatment OR 0.46 (CI 0.32-0.64) to prevent bacteraemia in the neutropenic patient. Analysis of subgroups showed comparable results for TMP/SMZ vrs placebo OR 0.39(CI 0.18-0.86) and for quinolones OR 0.31 (CI 0.17-0.58). Gram-negative bacteraemia's are also prevented in the total group OR 0.35(CI 0.21-0.58), whereas SDD does not prevent Gram-positive bacteraemia's OR 0.68 (CI 0.43-1.05).

Conclusions: By performing the extended literature search, and performing a quality-assessment independently by 2 reviewers it can be concluded that in patients with neutropenic episodes it is possible to reduce the chance of bacteraemia's, mainly gram-negative bacteraemia's by providing selective decontamination of the digestive tract.

945 POSTER

Analysis of pooled data from two Phase III studies of the NK-1 antagonist aprepitant to assess relationships between the incidence and control of cisplatin-induced acute vomiting and delayed vomiting.

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Vomiting that occurs 24-120 hours after administration of chemotherapy (delayed vomiting) (DV) can be correlated with acute vomiting (AV), which occurs during the first 24 hours after chemotherapy. If the correlation represents an unfavorable "carryover" effect, then prevention of AV should be sufficient to prevent DV. We explored the relationship of AV and DV using pooled data from 2 identically designed randomized double-blind Phase III studies of aprepitant (Ap), in which 1034 patients (pts) receiving high-dose cisplatin were given either a standard antiemetic regimen (SAR) consisting of ondansetron (O) 32 mg iv and dexamethasone (D) 20 mg po on day 1, and D 8 mg po bid on days 2-4; or an Ap-based antiemetic regimen (ApAR) consisting of Ap 125 mg po, O 32 mg iv, and D 12 mg po on Day 1, Ap 80 mg po and D 8 mg po on Days 2-3, and D 8 mg po on Day 4. Pts were categorized by the presence or absence of AV, and the incidence of DV was then evaluated between categories. Within each category of AV response, a between-treatment comparison of DV was also made (Table).

AV	DV	ApAR (pts)	SAR (pts)
Yes	Yes	47	116
Yes	No	22	20
No	Yes	77	127
No	No	374	260

Of the 838 pts with no AV, 634 (76%) had no DV. However, of the 205 pts with AV, only 42 (20%) had no DV. Among the 838 pts with no AV, 374/451 pts (83%) receiving ApAR had no DV while 260/387 pts (67%) receiving SAR had no DV. This advantage was also observed among the 205 pts with