revealing significant differences. The gains of adjuvant chemotherapy in colon cancer stage III are well established in the literature, but the benefits are comparably limited and may be even less if treatment is not provided as in the trials (early start after chemotherapy, 6 or more months of treatment, adequate compliance at least 60%).

1067

Analysis of the EORTC Melanoma Group 18952 randomized trial on 2 intermediate dose schedules of IFN-alpha2b compared with observation in 1388 patients with high risk melanoma stages IIB-III

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Introduction: EORTC 18952 is the largest adjuvant IFN trial ever conducted in melanoma. The efficacy of intermediate doses of IFN-α 2b (10 MU qd, 5d/wk,sc,4 wks followed by either (arm A) 10MU, sc, tiw, for ONE YEAR, or by (arm B) 5MU, tiw, sc for TWO YEARS, was compared to observation (arm C). in 1388 patients with high risk melanomas (T4N0M0, anyTN1-2M0). The intent-to-treat analysis has been used.

Results: A total of 740 pts developed distant metastases and 648 died; the median follow up was 4.2 yrs. The differences between the 3 arms were not statistically different neither in terms of distant metastasis free interval (DMFI) (p=0.22) not in terms of survival (p=0.40).

Endpoint		Control	1-year IFN-α 2b	2-year IFN-α 2b
Distant Metastasis-Free Interval	4-year rate (SE)	44.4% (3.1%)	44.6% (2.2%)	48.7% (2.2%)
	HR (95% CI)	1	0.95 (0.79-1.16)	0.85 (0.70-1.04)
	P2-value		0.62	0.11
Survival	4-year rate (SE)	51.8% (3.1%)	53.0% (2.2%)	55.1% (2.2%)
	HR (95% CI)	1	0.99 (0.80-1.21)	0.89 (0.72-1.10)
	P2-value		0.88	0.27

HR: Hazard ratio

Treatment regimens were relatively well tolerated with an overall reporting of grade 3-4 toxicities in about 10% of the patients in the treatment arms A and B. In contrast to a very low rate of haematologic and hepatotoxic events the constitutional symptoms such as fatigue, anorexia and mood changes including severe depression were the most frequent causes for reductions, interruptions and for going of treatment early.

Conclusions: One year treatment with highintermediate dose (10 MU) IFN-α 2b showed no effect at all whereas 2-year treatment with the lower dose with 5 MU had a marginal effect that failed to reach significance. Duration may therefore well be of more importance than dose.

The question whether IFN is a cytokine that requires long term maintenance treatment for a significant improvement of outcome is presently addressed in the EORTC18991 trial which investigates the impact of 5 years of treatment with PEG-Intron in comparison to observation in stage III melanoma.

1068

Breast cancer screening - status and perspectives

E. Lynge. *University of Copenhagen Panum Institute, Institute of Public Health, Copenhagen, Denmark*

Randomised controlled trial from Sweden have demonstrated that it is possible to reduce the mortality from breast cancer when mammography screening is offered to women aged 50-69 every second year. Based on these results, service mammography screening is now offered throughout Europe. Screening is, however, testing of healthy women, and screening therefore has both potential advantages and potential disadvantages. It is, furthermore, not a straightforward task to customize the trial results to routine health care, and quality assurance is therefore needed of all activities in the service screening programmes. The presentation will review the outcome of service screening. It will include available data on the effect of service screening on breast cancer incidence and stage distribution, the effect on treatment, the occurrence of false positive tests, the occurrence of false negative tests as measured by the proportionate interval cancer rate, and the effect on breast cancer mortality.

1069

Prostate cancer screening - status and perspectives

F.H. Schröder. *Erasmus University Dr Molewaterplein 40, Dept. of Urology/ P.O. Box 2040, Rotterdam, The Netherlands*

Screening for prostate cancer remains controversial in spite of positive indirect evidence that screening may effect prostate cancer mortality. This evidence is mainly related to the decreasing prostate cancer mortality in the US and to the so-called "Innsbruck screening study" which shows a 32% prostate cancer mortality in a geographical comparison. In the meantime, major randomized studies are ongoing in the United States and in Europe which will eventually produce the answer to most of the open questions. These relate to mainly: Does prostate cancer screening decrease prostate cancer mortality? What are the appropriate age-groups to be screened? What are the appropriate time intervals? At what time should screening commence? Can risk groups be identified which warrant more aggressive diagnostic strategies? Many of these answers will remain pending until the outcome of the ongoing randomized studies is known. However, intermediate endpoint evaluation at least give some clue. The European Randomized Study of Screening for Prostate Cancer (ERSPC) allows estimates of stage migration, leadtime, overdiagnosis, screening interval evaluation and other important features. The design of more appropriate screening tests is also subject of these protocols. Facts will be presented.

1070

Cervical cancer screening - status and perspectives

J. Cuzick. *Cancer Research Uk, Epidemiology, Mathematics and Statistics, London, United Kingdom*

Cervical screening has been the most successful cancer prevention programme ever implemented. However the approach does have limitations in terms of the infrastructure and expertise required, and is now more that 50 years old.

Ongoing audit is essential if high quality screening is to be maintained. The current performance of the England screening program will be reviewed. Results of a pilot audit based on the screening histories or lack thereof in women who develop cancer will be presented. Such audits should become routine for all organized screening programmes.

The human papilloma virus is now established as the primary cause in over 95% of all cervix cancers worldwide. It is readily detectable in material collected in a smear, and is an obvious candidate for screening. There are three potential roles for the test:-

i) Improving management in women with borderline or mildly dyskaryotic smears.

ii) Post-treatment surveillance to detect incomplete excision on CIN

iii) As a part of primary screening to improve sensitivity

HPV has better sensitivity for CIN 2/3 than cytology, and thus argues for its use in the first two situations. Questions of specificity are crucial in assessing its appropriateness in primary screening and a potential algorithm will be presented.

1071

Screening for colorectal cancer

O. Kronborg. *Odense University Hospital, Department of surgery, Odense, Denmark*

Organised screening for familial colorectal cancer (CRC) is in place in the Nordic countries, based on countrywide registers. Screening for metachronous neoplasia after curative treatment of sporadic CRC, usually is done by colonoscopy with intervals of a few years, but the predictive value of microsattelite instability may cause a substantial reduction of the number of colonoscopies.

Also colonoscopic follow-up in adenoma patients may bee limited, based on predictive value of different histopathologic features. Effectiveness of colonoscopic screening with multiple biopsies in patients with IBD is very minor.

The major impact on mortality from CRC will come from screening of the average population above 50 years of age. So far, the efficiency has been demonstrated in RCT's with fecal occult blood tests (FOBT's), and within the next few years flexible 60 cm sigmoidoscopy may be demonstrated to have a place in combination with FOBT's.

The evidence for a reduced incidence of CRC because of removal of polyps still is limited, but promising. Initial colonoscopy in average risk persons is not attractive because of immediate risk, cost, lack of doctors and inconvenience to the patients; nevertheless, colonoscopy has been suggested with intervals of 10 years.

Colonography has not been evaluated for screening purpose yet, but may be used when colonoscopy is incomplete.

Among other markers those of DNA are most promising, but multiple DNA alterations must be targeted.

At the present time, guidelines should be developed at national level for FOBT programs in average risk populations, based on feasibility studies in limited parts of the country, like it has been done in UK. It should be foreseen, that endoscopical, histopathological as well as radiologic services must expand.

Initial colonoscopy should be reserved for high risk groups.

1072

How to cope with cancer?

E. Rasmussen. *Mandag Morgen, Copenhagen, Denmark*

Coping with cancer demands a new partnership between doctors and patients and a new understanding of the social and psychological consequences of cancer. So far we have focused too much on the decease itself and too little on the patient. Cancer is not only a decease, but the biggest and toughest challenge that can hit a human being on all dimensions at one time. Therefore cancer should not alone be treated as a decease. In consequence of this doctors must either expand their own competencies or accept and cooperate with at much broader field of complementary treatments.

My presentation goes through the different stages of challenges the cancer patient has to cope with and suggests what kind of partnerships is needed at each stage to ensure the best possible outcome for every single patient.

1073

Optimizing the time between breast cancer diagnosis and treatment through Collaborative Care.

M. Mendelsohn, J. Belkora, L. Esserman. *UCSF, Carol Franc Buck Breast Care CenterUCSF Comprehen, San Francisco, USA*

When a woman receives a breast cancer diagnosis, she is flooded with emotions, information and questions. She is overwhelmed with the task of quickly learning the language of cancer terminology and the subsequent availability and choices of therapy. The Collaborative Care Program was developed to support women through the time period from diagnosis through treatment. This is a method that enhances medical provider to patient communication by taking them through a systematic and defined process that delineates questions, answers and options in a manner that is understandable to both participants in the decision process. The interventions may be both qualitative (Consultation Planning) and quantitative (Treatment Selection).

Medical providers are highly trained in the areas of diagnostic and therapeutic intervention but there is a lack of skill building within medical training that enables them to help patients in the science and art of decision making. The typical health care consumer lacks training in this same area. The gap between patient-provider aspirations and capabilities may be termed the Decision Gap. At the UCSF Carol Franc Buck Breast Care Center, providers are focused on tailoring treatment to biology and, very importantly, patient preference. The potential poor outcomes that can result from not employing these methods may include treatment related complications, poor resource utilization and patient as well as provider dissatisfaction.

There are many variables in patient preference regarding decision making. Often, patients feel intimidated by the medical environment, are worried about taking too much of the provider's time, and/or have difficulty synthesizing their concerns. The questions that patients seek answers to that will ultimately drive their decisions are sometimes not things that a provider would have any way to predict.

The Collaborative Care process is demonstrated through examples of particular cases that illustrate the outcomes that have demonstrated positive impact on patient and provider satisfaction, decision quality and communication while taking into account the decision quality conditions of frame, values, alternatives, information, reasoning and commitment.

1074

Continuity and quality from the time of the cancer diagnosis until the treatment is completed

A. Gregor. *Western General Hospital, Clinical Oncology, Edinburgh, United Kingdom*

Continuity of care and access to information are quoted as the two most pressing priorities for patients and clinicians. Modern management of cancer increasingly requires care delivered by teams of professionals working in different specialities and in diverse geographical settings. What are the characteristics necessary for effectiveness of multidisciplinary teams? 1 Are there specific roles which one or another professional group should lead in?2 Or is it the process of care that must be specified and supported by administrative actions and information management? Is the holy grail of continuity an outdated proxy for consistency of management and information or expression of medical dependency and paternalism?3

The task of this presentation is the initial part of "cancer journey" from the diagnostic interview, post diagnostic evaluation/ staging, multidisciplinary decision conference and formulation of a management plan, treatment delivery and evaluation and immediate post treatment aftercare. The formulation of a plan for follow up and rehabilitation is taken as the end of this process although most patients will need and have an ongoing clinical relationship beyond this rather arbitrary point.

The core relationships are between the patient his family, carers, various members of the hospital multidisciplinary team and the primary care team but may include employers, social services and external support staff from voluntary sector. The care process at this stage needs to be fast and decisions about prognosis and details of therapy which are of critical importance will depend on scenario which changes with the progress and outcome of the investigations and assessment.

Individual members of the clinical team have rarely access to the totality of the information and/or the expertise to come to a summated and accurate decision. At this stressful time patients and their family search for reassurance and certainety through multiple contacts with various members of the team and risk receiving conflicting information which further enhances their distress.

Variety of approaches to integrated care have been tested in clinical settings. Their summary could be expressed in a simple framework addressing *the four P's: pathways, personnel, protocols and "paper".*

- *Pathways* of care need to be defined so that patients and their clinical team know the plan including dates and places of key events.
- Each and every *member of the team* must know their own role and responsibility- agreement on communication strategy and content is a part of this process and patients need to know who and where to contact if they need to or get lost. Specialist nurses provide this case manager role most frequently, but other health acre professionals or even administrative staff may be just as useful providing they are trained and supported.
- *Protocols* provide guidance on what to do and how to do it with the explicit agreement and realisation that exceptions will happen.
- Under the heading of *paper* is the documentation and information needed. If this process is to be safe and efficient than the traditional forms of uni-professional assessment and letter writing between team members is not adequate- it must be supported by modern technology. A combination of an open web based information resource describing the process of care and a closed system of an EPR available under strict QA control and need to know basis to the clinical team provides the best compromise between open access to information and security of clinical data and has the additional benefit of being able to capture and report selected performance indicators as a by product.

Fundamental review of roles and responsibilities of all clinicians within the team are essential to redefine the new paradigm of doctor patient relationship. Clarity will improve the quality of the encounter and the experience for all parties involved. It needs to be done in a positive, flexible and systematic way with the patients at the centre of all considerations and recognise the cultural and professional barriers that will need to be crossed if such change is adopted and implemented in practice.

1075

Advocacy for cancer patients

A. Vinkel. *Danish Cancer Society, Department for Patient Support, Copenhagen, Denmark*

Through her 12 local counselling centres, national cancer helpline and rehabilitation centre Dallund, the Danish Cancer Society offers information and support to cancer patients and their relatives. In 2002 more than 26.000 counselling interviews were performed. Further a great number of activities