as they can provide expertise or are located close to the patient, and coordinates the process of consensus underlying shared criteria for patient care. Stored data feed a National Register of Rare Diseases instituted within a separate governmental project.

Results: Since 2003, a prototype has been available on the Web and has entered a testing phase on field. About 800 cases diagnosed with rare tumours (mainly sarcomas) have been registered. 230 patients have been virtually shared so far. 150 patients have moved physically across the network. Patient records have been used to automatically generate data-entry forms for selected clinical studies (this is currently implemented for some studies by the *Italian Sarcoma Group*). 524 patients diagnosed with GIST have entered an observational study on Gastrointestinal Stromal Tumours (GIST), aimed at increasing our understanding and improving quality of care in regard to this rare disease, recently revolutionized by molecular-targeted therapy. RTR has now been funded by governmental bodies to upgrade its technological core.

Conclusions: Cooperation among institutions is vital in the field of rare tumours, as well as, more generally, rare diseases. The Internet can support effective cooperation through dedicated Web resources.

564 POSTER

Towards comprehensiveness and excellency: the accreditation project of the Organisation of European Cancer Institutes (OECI)

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Background: There are important gaps in the health status of citizens across Europe, as measured by life expectancy, mortality or morbidity data (Report for the European Commission on the health status of the European Union, 2003). Among the main determinants of the major causes of mortality and morbidity, stated in this report, stands recurrently access to quality healthcare. There is a fundamental need to define quality indicators and set minimal levels of performance quality criteria for healthcare. There is a need to integrate research into healthcare and to provide equity of access of patients to such high quality care.

Materials and methods: Oncology is a speciality particularly suited to experimenting a first application of accreditation at European level. The Organisation of European Cancer Institutes is a growing network of 89 cancer Centres in 29 countries in Europe. The focus of the OECI is to work with professionals and organisations with regard to prevention, care, research, development, patient's role and education.

In order to fulfil its mission, the OECI initiated in 2002 an accreditation project with three objectives:

- To develop a comprehensive accreditation system for oncology care, taking into account prevention, care, research, education and networking.
- To set an updated database of cancer centers in Europe, with exhaustive information on their resources and activities (in care, research, education and management)
- To develop a global benchmarking tool dedicated to cancer centers in Europe, comparing both care and management activities.

Results: An accreditation manual has been established, defining standards and criteria for prevention, care, research, education and follow-up activities. A database of cancer centres is developed, with 2 versions of a questionnaire circulated among all OECI cancer centres, that give an overall view of the oncological landscape in OECI cancer centres in Europe. Data on infrastructures, resources and activities have been collected. The benchmarking project was initiated in 3 cancer centres and will be presented elsewhere.

Discussion: Quality assessment and improvement is a critical need in Europe and is addressed by the OECI for cancer care in Europe. Accreditation is a well accepted process and is feasible. Standards and criteria as well as an accreditation tool can be developed. The OECI questionnaire gives an accurate vision of cancer institutions throughout Europe, helping assessing the needs and providing standards.

565 POSTER

Screening chest radiography prescription in primary care: systematic review of literature and meta-regression analysis

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Objective: To assess whether the use of chest radiography for screening changes over time.

Design: Systematic review.

Data sources: Medline, ISI, Cochrane Central Register of Controlled trials, and hand searching of selected journals.

Review methods: We evaluated whether the proportion of primary care physicians using chest radiography to screen for:

a. malignancy in the general asymptomatic population
b. malignancy in a "high risk" population subgroup (like smokers)
c. any disease in the general population
d. any disease in "high risk" subgroups changed over time, employing random effects meta-regressions.

Adjustments for the availability of national guidelines were also performed.

Results: Despite screening chest radiography is being studied from the sixties and onwards, only 18 studies were eligible, and all but 4 reports were from the USA and Canada. Overall, between 10 and 90% of primary care physicians reported using chest X-ray for screening. In unadjusted analyses the proportion of physicians employing chest radiography for cancer screening in the general population tended to change by 0.9% per year, (95% confidence interval, CI: −2.4, 4.1%; 8 studies, n = 4,313). The corresponding annual change was −2.9% (95%CI: −4.5, 0.5; 8 studies, n = 2,784) for cancer screening in "high risk" subgroups, and −0.4% (95%CI: −3.1, 1.5; 7 studies, n = 2,627) regarding screening for any disease in the population. No meta-regressions were run for outcome (d) (only one study). In the adjusted analyses there was always a decreasing non-significant trend for all outcomes. High chest radiography prescription rates may be explained by the absence of national guidelines. Judging from Hellenic and French studies, it seems that the European Code Against Cancer do not have any impact on prescription practices, when specific national guidelines do not exist. The role of language barrier in such cases is debatable. Ignorance of the formal recommendations on the issue might be an explanation, especially in countries without a strong tradition in primary care medicine.

Conclusions: Despite the formal recommendations many physicians still use chest X-ray for screening. Their number seems to decrease slowly over time. This practice may be harmful, since the positive predictive value of chest radiography is low, and further evaluation of false positive findings might be associated with increased cost and risk from additional diagnostic and/or therapeutic interventions.

566 POSTER

Understanding the relationship between ethnic disparities and deprivation: a review of lung cancer in Maori and non-Maori in New Zealand

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In Aotearoa/New Zealand, there are significant and persistent disparities in health experiences and outcomes between Maori (the indigenous population) and non-Mäori, including stark disparities in cancer risk, incidence and outcomes. Lung cancer is one of the most common cancers in Aotearoa/New Zealand. Lung cancer incidence in Maori is 3.3 times higher than that of non-Maori, while the mortality rate is 3.7 times higher.

The differential distribution of socioeconomic deprivation by ethnicity is one explanation that has been suggested for these disparities. In Aotearoa/New Zealand, deprivation and other measures of socioeconomic position such as income and wealth, are strongly associated with ethnicity. This paper presents findings from a case study investigating the relationship between lung cancer, deprivation and ethnicity for Maori and non-Maori that was part of a larger study of disparities and deprivation.

The aim of the case study was to develop a better understanding of the extent to which the differential distribution of deprivation between Maori and non-Maori contributes to ethnic disparities in lung cancer outcomes, whether or not ethnic disparities in lung cancer exist at each level of deprivation, and whether or not the strength of the relationship between lung cancer and deprivation may be different for Mâori compared to non-Mâori (i.e. a gradient gap may exist).

Data from the New Zealand Cancer Registry on lung cancer registrations from 1995–1999 and lung cancer deaths from 1996–1999 were analysed by age, sex, ethnicity and deprivation using the NZ Deprivation Index (NZDep96). Poisson regression was used to examine disparities between Mâori and non-Mâori adjusted for age and deprivation.

The study found that adjusting for age and deprivation reduced the relative risk of both lung cancer incidence and mortality, but significant disparities remained between Maori and non-Maori. The results provide impetus for addressing disparities in lung cancer incidence and outcomes between Maori and non-Maori, including differential exposure to risk and protective factors, as well as inequitable access to timely and effective cancer care.