1324 PUBLICATION

Treatment decision-related factors in cancer patients

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Purpose: To find out the factors on treatment preference in cancer patients and to figure out the differences of values on treatment between the physician, family member and patient.
Material and methods: We enrolled the cancer patients with advanced or terminal stage and distributed the questionnaire to the physician and family member and patient if family member permitted in Seoul National University Hospital. The questionnaire includes these questions: 1) treatment preference according to the burden of treatment (low: a few days of chemotherapy vs. high: one month of ventilator care in intensive care unit), side effect (death, physical impairment, cognitive impairment) and the probability of side effect (1, 25, 50, 75, 99%), 2) concordance rate of opinions between the physician, family member and patient
Result: Total 121 cases were enrolled. Of these, 116 physicians (95.9%), 75 family members (80.6%) and 23 patients' opinions (19%) were available. As the burden of treatment increases, the acceptance rate decreases. (97.4% vs 82.1% in physician, 93.3% vs 86.5% in family member, 87.0% vs 69.6% in patient). With regard to the side effect, the acceptance rate decreases in order of death, physical impairment and cognitive impairment. (97.4% vs 78.9% vs 42% in physician, 93.3% vs 81.7% vs 49.3% in family member, 87.0% vs 72.7% vs 59.1% in patient). As the probability of side effect increases, the acceptance of each treatment decreases in all three parts. The concordance rate of opinions on treatment decision is decreasing according to treatment burden. On treatment with high burden, the concordance rate between physician and patient is 52.9%. Also the concordance rate of opinions decreases in terms of side effect, i.e. in order of death, physical impairment and cognitive impairment. The concordance between physician and patient on cognitive impairment is only 25%. Regarding probability of side effect, the concordance is lowest when the probability of side effect is 50%.
Conclusion: Treatment preference depends on treatment burden, sort of side effect and the probability of such side effect. And the concordance rate of opinions of physician, family member and patients are various. To determine the treatment in cancer patients, values held by physician, family member and patient should be considered as well as treatment burden, sort of side effect and the probability of side effect.

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The dose-dense chemotherapy: is more frequently the better?

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Background: Pre-clinical cancer models support the Gompertian principle of faster doubling times in smaller tumors. According to this model, the Norton-Simon hypothesis suggests that the most effective strategy is to expose the tumor to cytotoxic agents as frequently as possible to minimize re-growth between cycles. The availability of hemopoietic growth factors makes this approach feasible. We reviewed data of trials evaluating the feasibility of dose-dense chemotherapy and the role of concomitant G-CSF support in the treatment of chemosensitive solid tumors and hematological malignancies.
Material and methods: The principal databases (PubMed, CancerLit, Medline) have been checked using keywords relative to dose-dense, CT and myelotoxicity, and considered only for the most representative papers on breast cancer and malignant lymphomas.
Results: *Breast cancer*: Some pilot trials with dose-dense regimens in the neo-adjuvant setting have not shown any evidence of better outcomes. However two phase II randomized trials comparing dose-dense vs. standard interval schedule, have shown the superiority of dose-dense schedule in terms of pathologic complete response and breast conservative surgery. In adjuvant setting the dose-dense approach was evaluated in three large prospective randomized phase III clinical trials comparing dose-dense approach with G-GSF vs. standard interval treatment in pts considered at high-risk of recurrence: two of these trials showed the superiority of dose-dense approach in terms of DFS and OS.
Non-Hodgkin Lymphoma: The German High-Grade NHL Study Group demonstrated that elderly pts receiving CHOP every 14 days did better in terms of TTF and OS with respect to pts receiving CHOP at the standard 21-day interval. Similar results on OS were observed in younger pts randomised to be given CHOP or CHOP-etoposide, every 14 or 21 days. The duration of G-CSF treatment in these studies ranges from 6 to 10 days, and G-CSF support did not increase the non-hematological toxicity
Conclusions: Further understanding of the biology and behaviour of tumour cells may lead to significant improvements in the long-term prognosis for patients with early and advanced breast cancer. Preliminary data on breast cancer and NHL support the use of G-CSF during dose-dense regimens. Dose-dense schedule is still an investigational approach. The use of Peg-filgrastim in a dose-dense schedule approach need to be addressed.

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The first use EORTC quality of life questionnaire H&N35 in Danish

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Background: The quality of life questionnaire EORTC C30 with the head and neck specific module H&N35 has been validated in many languages and cultural settings, but not in Danish. This validation was the purpose of the current study.
Materials and methods: In a cross sectional study 116 of 120 (97%) recurrence free head and neck cancer patients returned a valid questionnaire. The patients were attending follow up after single modality treatment with either radical radiotherapy (N = 83) or surgery (N = 33) for cancer of the larynx (N = 44), pharynx (N = 34) or oral cavity (N = 38). Mean age was 63 years (range 36–92) and median follow up was 20 months (range 1–65).
Results: The compliance was high with only 1.6% missing answers. Sixteen patients did not answer the items related to sexuality; not answering these questions was significantly dependent on high age. The psychometric properties of the questionnaire previously described were confirmed with the Danish translation: Construct validity was comparable with previous results. Compliance was excellent and overall internal consistency was acceptable to excellent. Most of the scales of the questionnaire were sensitive to influence from patient, tumour and treatment related factors: Twenty of 33 scales showed significant differences between patients with WHO performance status 0 and *1. Eight scales depended significantly on age, among them HN Dry Mouth. The absolute correlation coefficient was very low (< 0.36). Among significant findings, age was invariantly negatively correlated with the symptom scales and positively correlated with the function scales. Gender also significantly but weakly influenced 3 scales with women having the most symptoms. Seventeen of the 33 factors differed significantly between initial tumour sites. After excluding the patients who had surgery (mainly oral cavity cancers) 7 items differed according to site. The difference depending of site was only present in the stage 1+2 group, probably because the stage 3+4 patients had irradiation of almost the same areas at least to moderate doses. Stage was significantly and positively correlated with 10 scales. The irradiated patient had the worst symptoms in all scales – significant in 23 scales. Among irradiated patients improvement was observed with increasing time since therapy in 13 scales. Among the patients whom had surgery 5 pain related scales (Pain, HN Pain, Constipation, Pain Killer and HN Nutritional supplement) worsened with time since therapy. No improvement was observed in any scale among the patients who had surgery with longer follow up.
Conclusion: The EORTC H&N35 in conjunction with EORTC C30 is a valid and informative tool in assessing the quality of life of head and neck cancer patients, also in the Danish translation showing important differences depending on age, gender, tumour site, stage, treatment modality and time since therapy.

1327 PUBLICATION

Male Cancer Patients' attitudes towards female physicians, female nurses and chaperones during urological consultations

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Objective: There is considerable literature regarding female patients attitudes towards male physicians and chaperones. It is well known that some women have a strong preference for female physicians particularly during pelvic exams (Rifkin. Acad Med. 2002; 77:1034–8). On the other hand, even though a significant proportion of the health professionals are females, male cancer patients' attitudes and preferences have not been well studied (Gupta. Hum Resour Health. 2003 22; 1:5) (Chur-Hansen. J Adv Nurs. 2002; 37:192–8). Hence, as part of a service development audit, we assessed male urological cancer patients' attitudes towards female physicians, female nurses and chaperones.
Patients and methods: A random sample of 89 patients completed a self-administered anonymised questionnaire during their routine follow-up clinic visits. The median age group of the patients was 51–70yrs (Age group 18 to 30yrs – 8%; 31 to 50 yrs – 30%; 51 to 70 yrs – 39%; above 71yrs –23%). 40% of the patients had testicular cancer and 60% had prostate cancer.
Results: Overall, 96% of patients surveyed felt that their privacy has been respected in the clinic and 93% of the patients mentioned that they and