18 breast (35%), 5 digestive (9%) and 1 bone cancer. Histological findings were of adenocarcinoma in most cases (71%) and 79% had bilateral NPL. Karnofsky performance scale ranged from 10 to 90% (median: 60%); 52% patients had other comorbidities (Charlson index ranged from 6−10; median 7); 48% were previous smokers (2–198 pack-years); hemoglobin levels ranged from 4.9 to 16.7 g/dL (median: 12); body mass index varied from 16.3 to 41 kg/m^2 (median: 24). We also evaluated 34 patients with echocardiography, and 38% of them had signs of associated pulmonary hypertension; ejection fraction ranged from 46 to 83% (median: 69%); diastolic dysfunction was present in 22 and pericardial effusion in 10 patients. Median SpO2 was 91% (range 80−98%); 45% of patients had hypoxemia. Half of the patients had associated stress symptoms (depression or anxiety). At accrual, median QoL scores were of: 34.7 (range: 9.2−83.9) for SF-36 (scale with 0 worst) and 64.8 (range: 0−93.9) for SGRQ (scale with 100 worst). Treatment is shown in table 1 – 50% had SF-36 improvement with 1 month of palliative and supportive treatment. Median survival was of 81 days (range: 0.2−44.5+ months); at 3 months it was of 48%, and 33% of the patients had an unusual longer survival of more than 6 months, still showing good QoL scores.

Table 1. Palliative pulmonary lymphangitis treatment

Corticotherapy	
Systemic	76.9%
Inhaled	13.5%
Opioids	
Weak	63.5%
Strong	53.8%
Oxygen	61.5%
Diuretics	61.5%
Inhaled therapy	
Ipratropium bromide	61.5%
Beta2-agonists	57.7%
Systemic oncological treatment	
Chemotherapy	59.6%
Hormone therapy	5.8%
Physical therapy	53.9%
Benzodiazepines	48.1%
Active palliative sedation	40.4%
Thoracocentesis	38.5%
Antidepressants	36.5%
Blood transfusion	23.1%
Pericardiocentesis	10%

Conclusions: Despite the fact that QoL is generally poor and survival is short for patients with NPL, some patients may have longer survival time and some improvement is possible with active palliative and supportive care.

1124 POSTER

Feasibility and efficacy of video-assisted home care for cancer patients on chemotherapy (medical care continuity-mcc project). the preliminary italian experience

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Background: Cancer patients on chemotherapy may require frequent administration of supportive medications and/or receive oral formulations of antineoplastic drugs. These treatments could potentially be followed with no hospital admission. We evaluated within an EU granted pilot study, an integrated equipment including computer, video-telephone and a high-definition camera to follow patients receiving chemotherapy during their stay at home.
Methods: The equipment allowed 24 h/day communication to an "intermediate physician" of AXA Assistance call-center with transfer to "Tor Vergata" Clinical Center (TVCC) when needed.Five cancer patients (median age 69) treated at TVCC were enrolled between Nov 2006 and Feb 2007. Patient selection was planned to include both metastatic and non-metastatic patients and based on the willingness to use informatic supports.Frequency of patient/doctor contact was calculated as total number of contacts per patient/total weeks of follow-up. All patients were provided with internationally validated and MCC-oriented questionnaires exploring the patient's general health status and opinions on potential improvement of medical assistance by MCC and on complexity of MCC technology. All questionnaires were to be completed at study entry and at the end of the experimentation.
Results: Patients were on chemotherapy for metastatic disease (2 breast, 1 colon) or with adjuvant intent (1 breast and 1 colon cancer). Median duration of experimentation and frequency of patient/doctor contact were 45 days (31–120) and 2.1 contact/week (1.4−5.6), respectively. Contacts were related to technical support and medical reasons in the 35% and 65% of cases, respectively. Overall, 100% positive opinions on MCC care were reported by all participants at the end of the study with a 35% conversion-rate when opinions before study entry were considered.Medical contacts resulted in 67% of cases in drug dose-adjustments (mainly pain-killers or medications for chemotherapy-side-effects) for metastatic patients and in 32% of cases in management of anxiety and post-surgical complications for patients on adjuvant treatment, thus reducing unnecessary hospital admissions by 15%.
Conclusions: The MCC equipment was well managed by both patients and caregivers, main positive changes being the perception that MCC may substantially improve medical assistance by virtue of a constant access to medical advice and reduction of unnecessary hospital admissions.
Partially supported by e-TEN grant 517495.

1125 POSTER

Chemotherapy has no impact on acute and late skin toxicity when combined with a hypofractionated regimen of breast irradiation

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Background: Hypofractionated whole breast radiotherapy for early breast cancer has been widely adopted in Canada following the results of the Cancer Care Ontario breast fractionation schedule study. Nonetheless, very few patients received chemotherapy in that study, and the toxicity of hypofractionated radiotherapy in patients receiving chemotherapy was not analyzed. We thus set to evaluate the impact of adjuvant chemotherapy on the incidence of skin toxicity in the setting of hypofractionated radiotherapy. Materials & Methods: We conducted a retrospective review of patients with breast cancer treated with hypofractionated radiotherapy consisting of 42.4 Gray in 16 fractions from 2004 to 2006 at the Jewish General Hospital. Patients undergoing lumpectomy with or without adjuvant chemotherapy followed by hypofractionated radiotherapy were included in this study. All patients were evaluated weekly during treatment and on scheduled follow-up visits by the radiation oncologist using the RTOG/EORTC acute and late skin radiation toxicity scale version 2. Furthermore, the EORTC breast cancer-specific quality of life questionnaire QLQ-BR 23 was mailed to all patients.
Results: 163 patients underwent hypofractionated radiotherapy during the study period, 27% (n = 44) of which received chemotherapy. All patients completed their radiotherapy treatment as scheduled. Radiotherapy boost to the tumor bed was more common in the chemotherapy group (n = 19; 43.2% of patients) compared to the radiotherapy alone group (n = 32; 26.9%). There was no statistically significant difference between the two groups with regards to acute skin toxicity of grade $\geqslant$3 (0% in the chemotherapy group vs. 5.3% in the radiation alone group; p = 0.06) or grade 1−2 (60.5% vs. 51.7%, respectively; p = 0.16). With regards to late skin toxicity, there was, again, no significant difference between the chemotherapy and the radiation alone group for grade $\geqslant$3 (0% vs. 2.63% respectively; p = 0.21) or grade 1−2 toxicity (29.3% vs. 30.3% respectively; p = 0.45). Data regarding quality of life and breast cosmesis is pending.
Conclusions: In our retrospective single institution review, it appears that the addition of chemotherapy to hypofractionated whole breast irradiation has no adverse effect on the incidence of acute and or late skin morbidity. Further investigations such as a multi-centre review are necessary to better elucidate the impact of chemotherapy on skin toxicity in the context of hypofractionated irradiation.