area for screening among the surveyed physicians. Both SOBT and sigmoidoscopy are prescribed at low rates. The usefulness of these tests in screening should be better emphasized since these tests are both recommended and widely accepted

1225 POSTER

Regional models of care for systemic therapy: standards for organization and delivery

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Background: Rapidly expanding indications for cancer systemic therapy combined with human resource and facility constraints require innovative approaches to deliver care that is safe, patient-centred, and evidence-based across Ontario, a province covering 1 million sq km, organized into 14 regions of varying size, each with about 1 million inhabitants. A systemic therapy project team was assembled to recommend the best way to organize the delivery of ambulatory systemic therapy in Ontario.
Methods: A core multidisciplinary panel reviewed the evidence and developed the standards. The panel used evidence-based analysis of relevant publications, an environmental scan of existing recommendations from other jurisdictions and expert opinion based on experience and consensus to formulate a standards document to guide treatment delivery. This was reviewed and amended by the full project team. The document was circulated to oncologists, family practitioners, internists, pharmacists, nurses and administrators who work in or have responsibility for systemic therapy in the regions for practitioner feedback.
Results: A Regional Systemic Treatment Network Model was developed in which Integrated Cancer programs (ICPs) provide comprehensive cancer services, leadership of quality and overall organization/coordination for the region. Systemic Treatment Networks (STNs) include ICPs directly linked to satellite centres and also affiliated to centres with their own systemic therapy programs to provide appropriate systemic therapy services for all regions under a common set of standards. Four levels of care are recommended, with complexity and availability of services differentiating the levels. For each level, standards were established for; 1. Providers and their roles, 2. Education for providers, 3. Service type and complexity, 4. Service volumes, 5. Quality assurance and safety, 6. Facility requirements, 7. Administrative and organizational responsibilities. The intent is to provide the same standard of care in the most appropriate setting within the appropriate time frame. STNs will implement, monitor and evaluate quality indicators.
Conclusions: A detailed review of the document including results of practitioner feedback as well as survey results from the 14 STNs to determine whether standards are being currently met will be presented.

1226 POSTER

Assessment of nutrition in cancer patients and its effect on treatment outcome – a study from a developing country

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Background: In developing countries 40% people suffer from mal-nutrition. It has been shown that a good nutritional status can reduce complications of treatment, strengthen the immune system and contribute to the patient's general well being throughout cancer treatment. A good nutritional status is therefore essential for optimal tolerable treatment of a cancer patient. The aim of our study was to see the nutritional status of cancer patients on diagnosis and effect of nutrition on outcome of therapy.
Methods: In this study we prospectively analyzed the nutritional status of 700 cancer patients in Netaji Subhash Chandra Bose Cancer Research Institute, a tertiary cancer center of eastern India during period from January 2004 to December 2006. The age range of the patients was 1month to 87 years (median age 37 years). The parameter analyzed were weight for age, total protein, serum albumin and mid arm circumference. The weight for age and mid arm circumference were taken as normal if they were between 3rd and 97th percentile curve of the growth chart recommended by the Indian Council of Medical Research. The albumin level and the total protein were considered normal if the value is equal to or more than 3gm% and 5.8gm%.
Result: It was seen that total 180 patients (25.71%) were low weight for age and 145 patients (20.71%) had low mid arm circumference. Total 140 patients (20%) had low serum albumin while 175 patients (25%) were low serum protein. Low weight for age, low serum albumin and low mid arm circumference were significant factors in remission, disease free survival and toxicity of chemotherapy (p value <0.001).
Conclusion: We conclude that mal-nutrition is a major finding in cancer patients in developing country like ours. The patient with mal-nutrition had less remission of disease, disease free survival and more toxicities during therapy as compared to well-nourished patients.

1227 POSTER

Childhood cancer pattern: a hospital based cancer registry from a developing country

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Background: More than 80% of world children live in developing countries where adequate medical care is limited. A very few studies have been done in the epidemiology of childhood cancer in the developing countries. Whatever studies have been done in Asia, the incidence of child hood cancer is 3−5% of all cancers. The aim of our study is to see the incidence of childhood cancer and their disease pattern from the hospital based cancer registry.
Material & Methods: During period from January 2000 to December 2006 we analyzed our hospital based Cancer Registry data in Netaji Subhash Chandra Bose Cancer Research Institute, Kolkata a tertiary cancer center in Eastern India. There were total 18000 patients who attended in our institution as Outpatients and Inpatients. Among them 1500 were the childhood age group (<18 yrs).
Results: In our hospital based cancer registry the patients of childhood age (<18 yrs) group were 8.33%. The distribution of patient according to the age group (1−5 yrs), (6−10 yrs) and (11−18 yrs) were 320 (21.33%), 754 (50.26%) and 416 (27.73%) respectively. Most frequently childhood cancer were Acute Lymphatic Leukemia 380 (25.33%), Lymphomas 376 (25.06%) (Hodgkin's disease 25%, Non Hodgkin's disease 75%), Round Cell Tumours 225 (15%) (Ewing's Sarcoma 33.33%, Primitive Neuro Endocrine Tumour 26.66%, Rhabdomyosarconma 22.22%, Neuroblastoma 12.44%), Brain Tumour 148 (9.86%) (Meduloblastoma 91.21%, Astrocytoma 8.78%), Wilm's Tumour 78 (5.2%), Acute Myeloid Leukemia 66 (4.4%), Germ Cell Tumour 62 (4.13%), Osteosarcoma 55 (3.66%), Chronic Myeloid Leukemia 42 (2.8%), Retinoblastoma 29 (1.93%), Soft tissue sarcomas and other malignancies 39 (2.6%).
Conclusion: The incidence of paediatric cancer in our study was higher as compared to other studies. Children in Indian subcontinent showed a different pattern of cancers with excess of Lymphomas (specially Hodgkin's Lymphoma) and Round cell tumours as compared to those reported in Western Literature.

1228 POSTER

Second malignant neoplasms after acute myeloid leukaemia in Great Britain 1970–2000

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Aims: To ascertain the risk, number and type of second malignancies occurring after treatment for childhood acute myeloid leukaemia (AML) in Great Britain between 1970 and 2000.
Methods: The population-based National Registry of Childhood Tumours was searched for subsequent malignant neoplasm (SMN) among cases of AML diagnosed 1970–2000. Pathology reports were sought from treating hospitals to confirm diagnosis of SMN.
Results: There were 2,396 cases of AML diagnosed among children aged under 15 years between 1970 and 2000, contributing 8,499 person years of follow up to the end of 2002. At that time, 567 individuals had survived at least 5 years from diagnosis and 345 had survived at least 10 years. Ten individuals developed SMN (see Table). Of these, seven had received total body irradiation (tbi), all within a year of AML diagnosis. The standardised incidence ratio for all SMN combined was 6.0 (95% CI 2.9−11.0). The most frequently observed second tumour was papillary thyroid carcinoma, and the 3 individuals with these tumours had all received stem cell transplant (SCT) with total body irradiation (tbi).