statements are "evidence-based" (i.e. "types of basis" are assigned to codified expressions on diagnostic and treatment "options", according to originally developed scales). Moreover, an effort is made to provide critical and descriptive information, with the goal of allowing as much as possible an individualized clinical decision making at the patient's bedside. Critical statements are intended to be consistent with what the European oncology community perceives as "state-of-the-art". In addition to the internal review process, a regular external feed-back process throughout Europe will be operating. START is under construction. The first chapters are available through the internet at the WWW address http://telescan.nki.nl/start/. START will also be distributed on CD-rom.

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Guidelines in the French System: The experience of the Rhone Alpes Area and the French Federation of Cancer center SOR program

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A Regional Cancer Network was set up in the Rhone Alpes Region (5.5 Millions inhabitants) including the CLB Regional Cancer centre and 20 hospitals located in the region. The major objective of this project was to improve the overall quality of care for cancer patients all over the region. Guidelines were developed by the 60 specialists of the CLB by using a consensus-based approach and they currently cover most of the cancer sites. The THESAURUS was made available for assessment and review to the associated hospitals at the end of 1994. The review and consensus-building process was conducted in 1995, consisting for each cancer site in a monthly discussion of 4 hours between CLB specialists and representatives of the hospitals. At the end of 1995 the CLB Thesaurus was accepted as the reference Thesaurus for the network and named ONCORA (ONCologie Rhone Alpes). A first evaluation of the impact of the Thesaurus on clinical practice was conducted at CLB in 1996 according to a before/after study design. Compliance with the Thesaurus recommendations was 19% before and 54% after for breast cancer patients ($p = 0.00001$), and 50% before, 70% after for patient with colonic cancer ($p = 0.009$). The most important variation observed was for breast radiotherapy and follow-up were the compliance rate improved for breast cancer follow-up from 31% to 80% ($p = 0.00001$). This improvement was shown to be related to the number of multidisciplinary meetings held to discuss specific strategies for patients. A first evaluation of the impact of the Thesaurus was conducted in parrallel in the 21 other hospitals in 1996. A National program for the development of evidence-based cancer practice guidelines was set-up in late 1992 by the French Federation of Cancer centres (FNCLCC) under the name "Standard, Options and Recommendations for the diagnosis and treatment of cancer" (SOR). The SOR guidelines development methodology is based on the recommendations for practice guidelines development of AHCPR (Agency for Health Care Practice and Research) and ANDEM (Agence pour le Development de l'Evaluation Medicale). The SOR program has been designed from the beginning to improve the overall quality of care of cancer patients all over the country and to provide reference material for quality of care assessment. It therefore includes an implementation phase intended to increase the uptake and use of evidence based recommendations by practionners involved in cancer care inside and outside cancer centres, and an evaluation phase to measure the actual impact of the program on clinical practices. These phases are currently under preparation and will be undertaken within the next three years. The FNLCC is also the coordinator of an European project named ECOLE (European collaboration for Oncology Literature Evaluation). This project is funded by the European Commission under the program "Telematics for Health Care".

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Evidenced based cancer nursing practice

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The provision of evidenced based practice has emerged as a popular concept in health care today. This paper sets out to establish the degree to which cancer nurses base their practice on sound scientific evidence. It will explore the many barriers to the provision of such evidence based cancer nursing practice including the lack of good evidence for many nursing activities, a lack of research awareness and limited skills in interpreting research findings and a lack of support and resources to implement change in practice. A discussion will follow on the factors which facilitate evidence based practice including the provision of funds for cancer nursing research, the provision of resources which will improve nurses' ability to read and interpret research findings and finally, by ensuring that relevant research findings are made available to nurses through various user friendly media. The paper will conclude by identifying the resources which are available currently to facilitate evidenced based cancer nursing practice in Europe and by offering some suggestions as to how European cancer nurses might overcome the many barriers they confront in their efforts to provide evidence based practice.

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The consensus process in Europe

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Purpose: To examine the methodologies applied within Europe for the development of consensus documents and guidelines for the management of cancer.

Methods: Various strengths of evidence are available for use in developing guidelines/consensus documents. This review will gather data from European groups producing these documents. The processes used by various groups will be examined to estimate whether the chosen tools avoid bias. This will include, the use of a protocol, the search strategy used, databases of controlled trials used and access to hands searching and the "grey" literature, explicit inclusion and exclusion criteria, validation of data extracted, methods for rating trial quality and quantitative analysis of the data collected. Where there are consensus statements or guidelines on the same topic, carried out in different regions or countries, these will be examined to see if they are consistent in their recommendations. Where possible, the influence of current practise and philosophy on the recommendations will be examined.

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Surgical treatment of brain tumors

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Treatment of brain tumors represents a very important chapter of neurological surgery. In fact, surgery is of primary importance in the management of benign or potentially anaplastic brain tumors. It not only provides histological diagnosis but radical surgical removal, when feasible, is the/or part of the goal standard treatment of a very large group of theses lesions.

Surgery is directed specifically against tumoral processes which are widely different and heterogeneous anatomically and histologically. Some of them are benign (meningioma, neuroma, adenoma, epidermoid, cyst...) and their treatment is essentially relying on surgery. Others are anaplastic or malignant (glioma, metastasis, lymphoma...) and surgery has to be associated with other treatment modalities (radiotherapy and/or chemotherapy) but remains crucial for the histological assessment of the lesion even obtained from stereotactical biopsy specimens. Whenever possible surgical resection must be proposed because it improves the patient's clinical and functional state and allows a better efficacy of complementary treatments when indicated. These factors correlate with the quality and length of the postoperative radiological and clinical remission.

1330

No abstract

1331

Local control in breast conservation

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Local recurrence after breast conservation undermines hope of cure, increases anxiety, may require mastectomy and recent evidence suggests it may increase the rate of distant disease and hence the risk of death. Treatment policies aimed at reducing local recurrence require careful evaluation.

In 300 patients we examined the incidence and extent of residual disease in the tumour bed following wide local excision. Tumour bed positivity was 39%, (in situ 21%, invasive 18%). Further surgery was advised on the

basis of the extent of tumour bed positivity. Mastectomy was performed in 33 patients and a further wider excision in 12. At a mean follow-up of 4.8 years there have been 6 local recurrences (2.2%) and 24 (8.8%) distant recurrences in the 267 patients whose final treatment was breast conservation. Tumour bed positivity was not associated with tumour or lumpectomy size but was associated with high grade tumours and those with EIC. Pre-operative factors which predicted tumour bed positivity included dense mammographic pattern, casting type calcification and absence of a mammographic tumour nidus.

This study demonstrates that disease is frequently more widespread than anticipated. Tumour bed analysis and selective re-excision results in a low local recurrence rate which may in turn reduce the rate of distant disease.

1332

Prostate cancer: Need for local control

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Locally confined prostate cancer is potentially curable. Failure of controlling the disease locally will provided an aggressive natural course lead to metastatic disease and an uncontrollable clinical situation.

Local control can be achieved by means of surgery and radiotherapy. There is no prospective randomized comparison available. Historical comparison points toward an advantage of local control by surgery. The impact of improved radiotherapeutic techniques (conformational radiotherapy) is at this moment still unknown.

Neoadjuvant endocrine management may improve the opportunity for local control by shrinking the primary tumor by about 30%. While in combination with surgery the proportion of patients who have positive margins of resection can be decreased, this is not reflected in an advantage in time to PSA progression. The situation seems to be more favourable for neoadjuvant endocrine treatment followed by radiotherapy.

1333

Radical surgery and preservation of sphincter function in rectal cancer

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Sphincter preservation and the cure of cancer are the two most important goals in the treatment of rectal cancer.

The application of advanced techniques of sphincter preservation such as intersphincteric resection and coloanal anastomosis allow sphincter salvage in 80% of cases with rectal cancer. For the remaining 20% the restoration of the sphincter is possible. We use for this purpose dynamic graciloplasty. In this method the gracilis muscle is transposed to the perineum and stimulated with an implanted pacemaker.

Continence is achieved by activating the pacemaker.

In a prospective study in 140 patients we could show that in an elective and curative situation no patient with rectal cancer needed a permanent colostomy.

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The role of local control for soft tissue sarcoma

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In soft tissue sarcoma (STS) there are no proofs that local recurrence (LR) has a direct effect on survival rate (SR). STS are a difficult model for investigation, because of the variety of clinico-pathological entities and the quality of local treatment is not yet standardized. Out of 1232 primary STS, operated in our Institute, the event of LR and SR were reviewed stratifying the series according to many factors. LR occurred after inadequate operations and adequately reoperated had no effect on SR, but those following operations performed after so-called adequate surgery had a worsening impact on SR: cause/effect relationship or case selection? All the patients definitely cured (free-disease interval >5 yrs) had the primary mass defitely controlled, and conversely all the patient who complained unmeanageable LR or persistent lesion died for disease. Between these two definitive points we traced a theoretical model evualting the impact of LR on SR. The curves suggest that for a range of LR between 0% and 30% the expected impact of LR on SR is only few % points, statistically irrelevant. In planning the treatment, it is for that demanded that surgery and radiotherapy should together provide a good level of LR (at least 70% as final actuanal value). Once reached this level of local control any further extension of surgical margins, if ever possible (i.e. amputation versus wide excision), will not improve the rate of cured patients, due to the development of metastatic disease, not influenced by the quality of local control. In conclusion: the local treatments should provide the best quality of local control, but when LR are reduced below 30% of operated cases, any extended operation which affects the quality of life or increases the risks for the patient is no longer justified.