they indicated which statement most influenced their decision concerning trial participation.

Results: 200 patients completed the questionnaire, of these 110 (55%) were women with breast cancer. Overall results showed that 143 (71.5%) patients accepted entry to a RCT. The main reasons nominated for participating in a trial were that "*others will benefit*" (23.1%) and "*trust in the doctor*" (20.3%). One of the main reasons for declining trial entry was that patients were "*worried about randomisation*" (19.6%). Results were analysed according to the type of trial on offcr., c.g. trials that examine a new versus standard treatment for cancer. Acceptance rates differed significantly, with a high acceptance rate for trials with an active treatment arm 80 (79.2%) compared with those with no treatment arm 41 (54.7%), p = 0.0004.

Conclusion: The study outlines a number of factors that appear to influence a patient's decision to accept or decline entry into an RCT of cancer therapy. An important factor is whether or not the trial offers active treatment in all arms of the study. Communication that promotes trust and confidence in the doctor is also a powerful motivating influence.

1103 POSTER DISCUSSION

Communication about sex between health care professionals and patients with ovarian cancer: Attitudes and beliefs versus reality

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Purpose: It is not known to what extent health care professionals (HCPs) talk to patients with ovarian cancer about the impact that the diagnosis and the treatment have on sexual functioning, nor whether patients think this kind of information is important. A study was performed in Leeds to investigate these issues.

Methods: Interviews were carried out with 16 clinicians and 27 nurses to investigate the importance that HCPs place on discussions about sexual problems, and views on lines of responsibility for such discussions. In-depth interviews were carried out with 16 ovarian cancer patients to determine the incidence of sexual problems, the underlying causes of sexual problems, the relative importance of sexual functioning to patients, and patients' views about whether sexual matters should be discussed.

Results: Although the vast majority (95%) of HCPs believe that sexual issues should be discussed with patients, only 4/16 (25%) of clinicians and 5/27 (19%) of nurses actually discuss sex with patients. Patients with ovarian cancer do find that their sex life is affected and feel that they would benefit from talking to someone about sex.

Conclusion: There is a need to improve communication with patients about sex, by encouraging and training HCPs to feel comfortable initiating discussions about sexual matters and/or by employing a psychosexual counsellor.

1104 POSTER DISCUSSION

Awareness of disease: A cross-sectional study on Italian cancer patients

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Purpose: Today, in Italy, there is a no uniform physician attitude and practice in regard to revealing the diagnosis of cancer, and, therefore, many cancer patients are not fully informed about the nature of their illness, its severity and curability. Because of the impossibility to directly obtain information on the lack of insight of disease, a cross-sectional study of cancer patients was carried out.

Methods: Two visual analogue scales evaluating curability and severity of disease were submitted to 6,098 consecutive cancer patients enrolled in 79 oncologic centers. Patients were asked to mark a point in a 100 mm long horizontal line with the extremes labeled with 0 (very easy to cure, not severe disease) and 100 (very difficult to cure, quite severe disease). Individual responses were classified in "easy to cure‰ and "not severe disease‰ if a point in 0–30 mm interval was chosen on the respective scales; "difficult to cure‰ and "severe disease‰ if a point in 70–100 mm interval was marked. Multifactorial analyses were performed using logistic models, for each of the 4 responses ("easy/difficult to cure‰; "not severe/severe disease‰), assuming as explanatory variables type and staging of cancer, patient characteristics, response to chemotherapy, and presence of 19 problems related to the patient, conditions.

Results: Disease was considered easy/difficult to cure by 3,020 (49.5%)/1,149 (18.8%) and not severe/severe by 1,810 (29.7%)/2,256 (37.0%) patients. Among patients who felt their disease was severe (2,256), only 863 (38.3%) considered it difficult to cure and 897 (39.8%) easy to cure; instead, among those who felt it as not severe (1,810), only 147 (8.1%) considered it difficult to cure and 1,479 (81.7%) easy to cure. The highest percentages of patients who believed their disease was severe were found among those affected by ovarian (48.7%) and lung (47.0%) cancer, while the lowest in those affected by uterine cancer (27.1%), lymphomas (27.4%), colon-rectal (33.0%) and breast cancer (35.3%). Also the staging was important in explaining the variability of the perceived severity: disease was considered severe/not severe by 29.2/36.2% of patients with NED, 38.8/29.0% of patients with localized disease, and 46.6/21.1% of patients with disseminated disease. Moreover, the percentages of patients who considered their disease severe/not severe were different among those who had a Karnofsky performance status 80 (47.0/22.8%) and among those with the highest values (32.1/33.1%). Finally, problems such as lack of optimism, difficulties in daily or working activities, anxiety about follow-up results, body change due to the illness more frequently led the patients to feel the severity of their disease. Similar results were obtained in analyzing curability.

Conclusions: Among Italian cancer patients the insight about the nature and prognosis of their disease is scarce. For example, only less than one half of the patients with disseminated disease felt it as severe and one fourth as difficult to cure. Therefore, some doubts arise regarding the validity of both a fully informed consent to therapy and the utility measurements, based on patient preferences.

1105 POSTER DISCUSSION

Predicting anxiety and depression among cancer patients

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Purpose: To investigate the possibility to predict anxiety and depression 6 months after the cancer diagnosis on the basis of measures of anxiety, depression (Hospital Anxiety and Depression, HAD scale), subjective distress (Impact of Event, IES scale) and some aspects of social support in connection to the diagnosis. To attempt identification close to the diagnosis of individual patients at risk for prolonged psychological distress.

Methods: A consecutive series of 527 newly diagnosed patients with various diagnoses were interviewed in connection to the diagnosis and 6 months later.

Results: Anxiety and depression close to the diagnosis explained 39% of the variance in anxiety and depression 6 months later. Patients scoring as doubtful cases/cases for HAD anxiety and/or depression were above 11 times more likely to score as doubtful cases/cases at 6 months. Additional risk factors for elevated anxiety and/or depression were having an advanced disease and nobody in addition to the family to rely on in case of difficulties.

Conclusion: Levels of anxiety and depression at diagnosis predict a similar status 6 months later. Having an advanced disease and nobody besides the family to rely on in case of difficulties are additional risk factors.

1106 POSTER DISCUSSION

A comprehensive assessment of satisfaction with care: Preliminary psychometric testing in oncology settings from France, Poland and Italy

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Purpose: Satisfaction with care may be closely related to quality of life in cancer patients. International clinical research might thus find valuable information in patients' satisfaction with care assessment. This study was aimed at testing whether equivalent factor structure and scales demonstrating adequate internal consistency and convergent-discriminant validity estimates could be found in a Comprehensive Assessment of Satisfaction with Care (CASC) across oncology settings from Italy, France and Poland.

Methods: 290, 140 and 186 patients were approached before discharge from oncology hospitals in Italy, France and Poland respectively. They received the CASC to compile at home.

Results: Factor analyses evidenced the same dimensions for doctors' items cross-country but factors for nurses and services/general satisfaction items could not be interpreted similarly. Multi-trait scaling analysis on an item-grouping adapted for the French, Polish and Italian samples provided very good internal consistency and convergent validity and acceptable discriminant validity estimates.

Conclusion: These results provide a rationale for pursuing the development of the CASC namely with the aim of designing a short form.

1107 POSTER DISCUSSION

Self-reported quality of life (QL) of individual cancer patients – Concordance of results with clinical course and medical records

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QL instruments have been developed for comparison of group of patients in clinical trials and their use for monitoring individual patients is not established. The **aim** of this study was to examine the concordance between self-reported QL of cancer patients and the course of their disease as reflected in the medical records.

Patients and Methods: Cancer patients attending the outpatient oncology clinic over a 6-month period completed EORTC QLQ-C30 on a touch-screen computer at each visit. The corresponding records in the medical notes were reviewed and coded into symptom and functional categories.

Results: EORTC QLQ-C30 was completed between 1 and 10 times by 107 patients. Analysis at individual patient level was performed descriptively using case reports reviewed together with the QL profiles. The serial measurement of QL of individual patients allowed recognition of patterns over time compatible with the clinical course. At group level the medical records overall documented less problems than the QL instrument (nausea 5% of records vs 36% on EORTC QLQ-C30, insomnia 2% vs 61%, fatigue 13% vs 66%, emotional distress 8% vs 63%). Problems which were not recorded tended to be of low severity and this trend was statistically significant for all symptoms (except insomnia) and for the physical function and QL scales.

Conclusion: QL scores corresponded to disease/treatment course in individual patients. They provided more information than the medical records. The clinical relevance of this information and its potential impact on patients' management are currently being assessed in a prospective study.

1108 POSTER DISCUSSION

Attidudes of physicians and oncologists towards unconventional cancer therapies (UCTs)

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Purpose: While patients' motivation for using UCT and the prevalence of UCT in various countries has been studied there is little known on physicians' views on UCTs and physicians' decision whether to offer UCTs or not.

Methods: 1810 physicians attending the congresses in 1998 and 320 general practitioners were asked to complete a questionnaire on their attitudes and knowledge concerning UCTs. 833 questionnaires (40.4%) were available for data analyses using cross-tabulation, general linear models, and discriminant analysis.

Results: The following factors were found to be distinct between providers and non-providers of UCTs (in descending order): Degree of knowledge about UCT, place of work (office > hospital > university clinic), wish for coverage of UCT costs, the belief in future positive trends concerning UCT, physicians' gender (male > female), patients' demand for UCT, the number of patients seen per month, physicians' age (older > younger). GPs were found to be the main providers of UCTs. The rates of provision of UCTs varied considerably among various medical specialities (all differences are significant; $p < 0.001$).

Conclusions: GPs were identified to be the main providers of UCTs probably because they actually live among and with the cancer patients and remain responsible especially when conventional treatments fail. Since no UCT can be considered efficacious it seems necessary to educate physicians on alternatives from conventional medicine with lesser socio-economical impact as well as on better coping strategies treating moribund cancer patients.

1109 POSTER

Temporal trends in childhood leukaemia in North West England: 1954–1997

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Purpose: To conduct analyses of the temporal trends in the incidence of childhood leukaemia diagnosed between 1954 and 1997, using Manchester Children's Tumour Registry data.

Methods: Poisson regression was used to examine secular trends. Additionally scan statistics were used to look for temporal clustering. A comparison was made between acute lymphoblastic (ALL) and acute myeloid leukaemia (AML).

Results: The annual incidence of childhood ALL showed an upward but non-significant trend. The observed increase was 0.015 per 100,000 person years per annum ($p = 0.22$) The observed incidence pattern for the 1–4 year age group appeared to be cyclical over time with peaks and troughs. A preliminary comparison with a study of space-time clustering showed peaks occurring in years when space-time clusters were observed supporting the concept of periodic mini-epidemics. The concentration of both space-time clusters and the cyclical pattern of incidence in younger cases suggests that it is mainly c-ALL which is involved. The rates for AML were stable throughout the period of the study and showed no cyclical variation.

Conclusion: Results are consistent with an aetiological role for infections in childhood ALL, particularly c-ALL

1110 POSTER

A case control study about HTLV-I in lymphoid malignancies (LM) with special reference to adult t-cell leukemia-lymphoma (ATL)

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We conducted this prospective case control study between 1996–97 in order to determine the incidence of HTLV-I in LM, compare the outcome and the infection rates between positive and negative pts. 584 blood samples drawn from adult LM pts attended in our institution in a consecutive setting until completing the previously calculated number (Kish & Leslie), were tested for HTLV-I (ELISA: Platelia HTLV-I New Brand-Sanofi Pasteur). The compilation of data was made through a codified questionnaire. Definition of groups: CASE (C): patient with LM(+)/HTLV-I(+); CONTROL1 (C1): LM(+)/HTLV-I(−); CONTROL2 (C2): LM(−)/HTLV-I(−). We identified 42/584 (7.9%) positive pts, those were matched with C1 and C2 by age, sex and LM-type. One case with NHL associated with HIV was found. In C-group 3/95 (3%) were ALL, 35/354 (9%) NHL and 4/584 (0.7%) ATL.

The next table resumes the main results:

	Cases (C)	Control 1 (C1)	P
Mean Age (yrs)	55	53	
Homosexual	3 (7%)	1 (2%)	0.008a&*
CR to treatment	13 (48%)	27 (69%)	0.085b
Infection:			
– No infection	10 (24%)	24 (57%)	0.002b*
– Bacterial events	27 (52%)	19 (62%)	0.406b
– Opportunists events	11 (21%)	3 (10%)	0.177b
– Viral events	3 (6%)	3 (10%)	0.666c
OS: Mean (mths)	9 (CI:6–12)	23 (CI:20–27)	0.001d*
DFS: Mean (mths)	14 (CI:10–18)	25 (CI:22–29)	0.001d*

a: McNemar; b: Chi-square; c: E. Fishers; d: Logrank; &: OR = 0.28; CI: CI95%, *: Significant value

All were Hispanic race and 62% female. There were no differences by mother lactation, previous diseases, familial neoplasia, dental treatments and tattoos. The comparisons between C and C1 by haemoglobin, LDH, B-symptoms, Performance status, and staging were not significant. The CR rate had not significant difference between C and C1 although OS and DFS had significant difference. In conclusion: The incidence of HTLV-I in adult