tion 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

LM is high and response rate, OS and DFS are critical. The infection rate is high including opportunistic, bacterial and viral infections. HTLV-I must be incorporated in the initial evaluation of all cases of LM in endemic areas.

1111 POSTER

Psychosocial implications of prophylactic bilateral mastectomy

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Purpose: Prophylactic bilateral mastectomy is a radical surgical intervention so the psychological costs and benefits of this procedure need to be established.

Method: In this study psychological morbidity is measured, the decision making process described and pre-operative factors that may predict post-operative distress are being identified. To date 78 women opting for surgery and 63 women who have declined surgery have been interviewed. All women are assessed using standard psychological questionnaires prior to the decision about surgery and again at 18 months.

Results: Interim analysis shows that a higher percentage of women opting for surgery felt it was **inevitable** that they would develop breast cancer, regardless of risk estimates provided by their geneticist. Furthermore women opting for surgery are more distressed than those opting for regular surveillance. A factor that appears to be strongly associated with decision making, especially to have surgery, is personal family history and experience of breast cancer. Other issues that are emerging include: lack of support, concerns regarding implants, worry about follow up and communication.

1112 POSTER

Cancer mortality trends in Serbia

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Serbia has a population of 10 million inhabitants. Cancer is the second leading cause of death, after cardiovascular diseases. About 17% of the total mortality in Serbia today is due to cancer. In 1970, the share of cancer mortality was 11%. Crude cancer mortality rate has almost doubled since then (from 90 per 100,000 in 1970, to 177 in 1995) while the increase in age-adjusted rates was about 45%. The structure of mortality in Serbia resembles that in other European countries, particularly eastern and central European ones. There are similarities in cancer patterns in the Balkan countries.

There have been changes in the distribution of site-specific cancer mortality. The most frequent cancer sites in 1970 were: lung, stomach, liver, breast, rectum and cervix. Since then, there has been a two-fold increase in lung, breast, colon and rectum rates while stomach and cervix rates have decreased. Today, leading cancer sites were lung, breast, stomach, rectum, liver, and colon.

There are marked regional differences in cancer mortality in Serbia. The highest rates are in the northern province of Vojvodina, somewhat smaller in Central Serbia and significantly lower in the province of Kosovo: age-adjusted rates (according to the standard world population) were 146, 116 and 73, respectively.

1113 POSTER

The prevalence of smoking among junior hospital doctors; a cause for concern

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The importance of a strong, unified, anti-smoking message from the medical profession is crucial in order to deter people from smoking. One third of the Irish population smoke. Smoking rates among younger age groups in Ireland and other countries are rising.

We conducted a survey at our institution to assess smoking patterns among junior doctors and to determine whether junior doctors, regularly advise patients not to smoke.

Over a two week period, we attempted to survey all 156 junior Doctors in St. Vincent,s. A total of 107 doctors completed the questionnaire; 79 at interview and 28 by telephone.

Demographics: n = 107, Median Age: 28 [range 23–46], Male: 66 (62%), Female: 41 (38%) <3 yrs-qualified: 51 (48%), >3 yrs-qualified: 56 (52%) Irish: 84 (79%), Non-Irish: 23 (21%)

Results: 41% of junior doctors have smoked at some stage and 30% (n = 32) continue to do so. There are no differences in rates of smoking between male and female doctors nor between Irish and non-Irish doctors.

Twenty nine percent of those <3 years-qualified smoke compared with 41% of those >3 years-qualified (p = 0.208).

Doctors start smoking at median age 19.5 [14–30].

Fifty-six percent of current smokers would like to quit smoking, while 44% do not wish to stop.

One third of the 107 junior Doctors surveyed, report that they do not regularly advise patients against smoking. Doctors who are current or ex-smokers are more likely to regularly advise their patients not to smoke than are those who never smoked (46% Vs 31%, P = 0.137).

The prevalence of smoking among junior Irish doctors (30%) is approximately the same as the national average. The relatively high rates in this group may indicate high levels of stress and/or job dissatisfaction. In keeping with this view, doctors appear to start smoking relatively later (median age 19.5) than other new smokers, many (56%) do not wish to quit, and there is a non-significant trend for smoking prevalence to increase with length of time qualified.

1114 POSTER

Psychosocial factors predicting disease course in cancer patients

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Purpose: The possible role of psychological factors in the prognosis of cancer has been studied a lot with inconclusive results. In a prospective study the contribution of different psychosocial variables, mainly cognitive and emotional, to prognosis in cancer was evaluated.

Methods: The main instrument was a questionnaire assessing beliefs of 4 types (about self, goals, norms, and general) in regard to themes found in pretests to be prognostically relevant. Subjects were 120 cancer patients (breast, melanoma, colon). Follow-up extended up to 12 years.

Results: The questionnaire scores predicted the duration of the disease-free interval. Predictions were correct in 86% of the cases. Results of the Kaplan-Meier survival analysis were significant. Themes of particular importance were self-esteem and emotional expression.

Conclusions: The subjects' beliefs about specific themes enable predicting disease course, and hence their role in the prognosis deserves to be examined.

1115 POSTER

Comparison of the evaluation of the subjective quality of life in cancer patients by themselves and by their physicians

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Purpose: The increasing interest in quality of life (QOL) in cancer patients raises the question of how different aspects of QOL are assumed by their physicians.

Methods: 7 QOL dimensions assessing the patient's present state, changes over the last two months, and expected changes for the coming six months were used. 67 cancer patients with different diagnoses and their doctors participated in this study.

Results: Patient-physician correlations for the patients' present QOL ranged from 0.78 for pain to 0.16 in social status. Correlations were higher for traditionally medical QOL dimensions (physical functioning, pain, and subjective health) than for other aspects of QOL (negative affect, positive affect, social status, and global quality of life). Doctors found it harder to answer these latter questions, since these issues are less discussed at visits. In addition, doctors tend to assume their patients' present state in different QOL aspects less favorably, perceive the past changes and the prospects for the future less positive than cancer patients.

Conclusion: Physicians are more accurate and more confident about their judgments when assessing the physical functioning, pain, and subjective health of cancer patients than other aspects of QOL. The higher correlation found in the former areas is due to the fact that those issues are more discussed at doctors visits.