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