were studied jointly. BC pts developed G1 anaemia but the pts with CRC developed virtually no anaemia.

Results:

	1st cycle	3rd cycle	Final cycle	P
CDDP Group (n = 12) Mean Hb (g/dl)	14.7 ± 1.6	10.4 ± 1.2	8.5 ± 1.2	p < 0.0001
Median EPO (mU/ml)	5.3	31.5	1.8	p < 0.0001
(range)	(1.2–20.0)	(1.8–73.0)	(0.2–10.8)	–
CMF Group (n = 10)				
Mean Hb (g/dl)	12.4 ± 0.7	12.2 ± 0.7	11.5 ± 0.8	p < 0.002
Median EPO (mU/ml)	4.0	8.0	4.1	p = NS
(range)	(1.0–48.0)	(3.1–89.0)	(1.6–33.0)	–
5-FU + LV Group (n = 10)				
Mean Hb (g/dl)	12.0 ± 0.8	12.4 ± 0.8	12.9 ± 1.1	p = 0.054
Median EPO (mU/ml)	7.5	12.5	18.5	p < 0.045
(range)	(2.5–22.0)	(2.4–276.0)	(5.0–600.0)	–

Conclusions: a) The cisplatin schedules analysed were associated with intense inhibition of the EPO response, b) The inhibition caused by CMF was less intense; c) 5-FU + LV seems to stimulate the synthesis of EPO.

1482 PUBLICATION

Epoetin alfa (EPO) prevents anaemia and improves quality of life (QOL) in cancer patients (PTS) undergoing platinum-based chemotherapy (CT)

F.J. Carabantes, C.J. Alonso[1], F. Rius, M. Benavides, M.L. Hebrero, S. García, M. Cobo, R. Trujillo, J.J. Bretón, C. Juárez. *Medical Oncology Section; [1]Department of Biochemistry, Hospital Carlos Haya, Málaga, Spain*

To evaluate the impact of EPO on anaemia secondary to platinum-based CT, 52 pts with small cell lung cancer (n = 27) or ovarian cancer (n = 8) were included from Jun-95 to Nov-97. CT consisted of 6 courses every 21–28 days (d) of one of these schedules: CDDP + VP-16, CBDCA + VP-16, CBDCA + CTX, CDDP + PTX. All pts were initially non-anaemic (Hb > 11.5 g/dl), and were separated into two groups depending on whether their Hb values fell to ≤11.5 g/dl after the first or second course (Group A) or not (Group B). Group A pts were then randomized to receive EPO 150 U/kg SC three times weekly, starting on the first day of CT (Group A_{EPO}) or no EPO (Group $A_{no\ EPO}$). The Nottingham Health Profile was used for QOL analysis, and 39 pts were evaluated (A_{EPO} = 15, $A_{no\ EPO}$ = 11, B = 13).

Results:

Group	Initial Hb (mean ± SD)	Hb at inclusion (mean ± SD)	Final Hb (mean ± SD)	No. of pts transfused
$A_{no\ EPO}$ (n = 15)	12.8 ± 1.3	10.5 ± 0.8	8.8 ± 1.4	13 (87%)
p	*NS*	*NS*	*<0.001*	*<0.001*
A_{EPO} (n = 20)	12.5 ± 1.2	10.5 ± 0.8	11.5 ± 1.8	4 (20%)
p	*NS*	*<0.001*	*NS*	–
B (n = 17)	13.4 ± 0.9	12.4 ± 0.7	11.5 ± 1.3	0

At inclusion no significant differences between groups were found in QOL, but at the end of treatment, it was increased significantly (p < 0.05) in groups A_{EPO} and B versus group $A_{no\ EPO}$.

Conclusion: EPO prevents anaemia, reducing the risk for transfusion and improves QOL in pts undergoing platinum-based cyclic CT.

1483 PUBLICATION

Palliation of bone metastases: A survey of patterns of practice in Canada

E. Chow, C. Danjoux, R. Wong, E. Szumacher, E. Franssen, L. Andersson, R. Connolly. *Toronto-Sunnybrook Regional Cancer Centre, University of Toronto, Canada*

Purpose: To determine the patterns of practice of radiation oncologists in Canada for the palliation of bone metastases.

Methods: A survey was sent to 300 practicing radiation oncologists in Canada. Five case scenarios with bone metastases were presented.

Results: A total of 172 questionnaires were returned (57%) for a total of 860 cases. 819 cases (95%) were treated with radiotherapy and 708 cases (82%) with external local fields (LF). Of those LF employed, doses ranged from a single 8 Gy to 30 Gy/10 fractions. 571 cases (81%) were treated with a short course of radiotherapy (a single 8 Gy – 17%, 20 Gy/5 fractions – 64%). 71 cases (10%) were treated with 30 Gy/10 fractions. With respect to the primary cancer: lung, breast and prostate, the proportions of using a single 8 Gy were 16%, 16% and 31% (p = 0.056); 20 Gy/5 fractions, 65%, 64% and 51% (p = 0.22); and 30 Gy/10 fractions, 9%, 12% and 5% (p = 0.16) respectively. Half body irradiation (HBI), and radionuclides were recommended more frequently in prostate cancer than in breast cancer (46/172 vs 4/172, p < 0.0001; 93/172 vs 10/172, p < 0.0001 respectively). Biophosphonates were recommended more frequently in breast cancer than in prostate cancer (13/172-7% vs 1/172 – 0.6%, p = 0.001).

Conclusion: LF remains the mainstay of therapy and the most common fractionation for bone metastases in Canada is 20 Gy in 5 fractions compared with 30 Gy/10 fractions in US. Despite randomized trials showing a single 8 Gy fraction is equivalent, the majority of us still advocate 5 fractions. There is a trend of utilizing HBI more in prostate cancer and biphosphonates in breast cancer.

1485 PUBLICATION

Quality of life (QoL) and treatment-related symptoms in postmenopausal women with metastatic breast cancer (MBC) during hormonal treatment (HT)

A. Alonso[1], A. Lluch[2], B. Massutí[3], E. Manzano[4]. *Proyecto Español Calidad de Vida y Hormonoterapia en Cáncer de Mama; [1]H. Gregorio Marañon Madrid; [2]H. Clínico Universitario Valencia; [3]H. Gral. Universitario Alicante; [4]Zeneca Farma Madrid, Spain*

Purpose: Multicenter national study in patients (p) with MBC receiving HT.. Assessment of QoL in this subset of p. Specific survey of HT-related symptoms. Analysis of relation between QoL and HT. Patient's preference in MBC.

Methods: 226 p with MBC under HT were selected during a 9-month period. Two self-administered questionnaries were used: FACT-B for QoL and modified C-PET for symptoms (25 items). Centralised analysis of forms was carried out.

Results: Socio-demographic: 75% of p were older than 65 year and 92% had descendants and 42% reported sexual activity in last 12 months (m). HT: 50% antiestrogens, 27% aromatase-inhibitors and 24% progestins. Mean-time under HT was 15 m, being longer (21 m) for antiestrogens. The most frequent reported symptom was tiredness (79%), and 13 out of 25 symptoms were present in more than 50% of p (restlessness, decreased libido, depression, anxiety, muscle cramps, insomnia, constipation, weight gain, mouth-dryness, irritability, stress, difficulty to concentrate) Self-reported (SR) QoL, ranging 0 to 6 shows a mean of 3.77 with SD 0.51 and only 17.7% of p consider as bad (0–2) their QoL while 37.1% of p rate QoL as good or excellent (5–6). P receiving antiestrogens and with more than 12 m in HT report better QoL. For FACT-B subscales (quantitative value 0–4) means were physical 2.99, social/family 2.56, relationship with doctor 3.37, emotional 1.67, functional 2.15, other concerns 2.11. P with antiestrogens HT showed a better physical subscale and this domain shows a significant correlation with self-reported QoL.

Conclusions: Majority of MBC postmenopausal women under HT report many symptoms in a systematic surveillance. Intensity is predominantly mild. Mena SR-QoL is 3.77 (0–6 scale) being better for antiestrogens and for p with longer HT. For FACT-B better means were observed in relationship with doctor and social/family well being domains but physical well-being seems to show better correlation with SR-QoL. Lower score was obtained in emotional well-being. SR-QoL seems to be a consistent summary measurement that correlates with symptoms and specific tool (FACT-B). First-line HT and length of treatment (response) seems to correlate with better QoL

1486 PUBLICATION

Should the depression sub scale of the Hospital anxiety and Depression scale be used as a screen for depression in patients with advanced metastatic cancer?

M. Lloyd-Williams, T. Friedman, N. Rudd. *Leicestershire Hospice, Groby Road, Leicester LE3 9QE, United Kingdom*

Introduction: The Hospital Anxiety and Depression scale (HAD) is used in outpatient clinics and elsewhere as a screen for depression in patients with advanced metastatic disease, using pre established cut off thresholds of 8 for all possible cases and 11 for all probable cases of depression. However the HAD has not been validated for use in this population and previous studies have suggested it does not perform equally when used in patients with differing disease status.

Aims: The aims of the study were to determine the efficacy of the depression sub scale in patients with advanced metastatic disease.

Method: Patients with a diagnosis of advanced metastatic cancer were asked to complete the HAD scale and were also interviewed by using the Present State Examination.