

province in Spain with a continental climate and a lot of hours of sun in a day. There was severe deficiency in 60 patients (47.2%), moderate deficiency in 61 patients (48.8%), recommended level in only 5 patients (3.9%) and no-one had toxic level.

Conclusions: 96% of patients in first visit in our Clinical Oncology Department had severe or moderate deficiency of Vitamin D, in February and March. We don't know by the moment if that deficiency is important in the risk of cancer, recurrence or response to treatment, but we think that we should, as oncologists, be aware of that deficiency, that is usually not recognized in current practice, and prevent and treat it, with recommendations about sun exposure +/- supplements.

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POSTER

Personal and Economic Barriers to Breast Cancer Screening Among Egyptian Females

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Background: Egyptian women did not utilize breast cancer screening service. The potential causes for this problem include personal, economic and healthcare service barriers. No studies addressing barriers to breast cancer screening among Egyptian women could be traced.

Methods: To determine personal and economic barriers to breast cancer screening among Egyptian females and to detect the best media channel to increase awareness about breast cancer screening. Cross-sectional survey was conducted. A structured interview questionnaires was used, Six hundred females aged 40 years or above, who never sought breast cancer screening service before and never been diagnosed with breast cancer were interviewed in the Family Health Centres in Alexandria governorate, Egypt.

Results: Multiple personal and economical barriers were reported. The interviewed Women don't seek medical advice unless they are sick 81.8% and not to perform any investigation unless ordered by a physician 77% were the most reported barriers. Lack of information about screening mammography was seen as a barrier in 69.2%, fear to get diagnosed with cancer 49.3%, shyness to be exposed to strangers 39.2%, fear of mammography pain 25.7% or exposure to radiation 25.5%.

The most common encountered economic barriers was the expense of the medical service; mammography 64.6%, transportation expenses was seen as a barrier in 44.1%, also lack of time to perform mammography 26%. Women who have ever seen advertisement about breast cancer screening were only 38.4%, they prefer to receive information about breast cancer screening from television 41%, from doctors and nurses 39%.

Conclusion: Cultural concept of seeking medical advice only at sickness is a major barrier against breast cancer screening in Egypt, misconceived information about pain and radiation exposure from mammography and shyness from performing mammography are common barriers, mammography expenses and transportation expenses are the main economic barriers to breast cancer screening.

There is need for more public information about breast cancer screening awareness campaigns that recognize these barriers and addresses culturally specific issues preferably done through television and directly from health care professionals can have impact and may improve utilization of breast cancer screening among Egyptian women.

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POSTER

Cancer Waiting Times: Assessment of One Month Wait Target From Diagnosis to Treatment of All Cancers in England

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Background: Over the last few years, National Health Service (NHS) in UK has focussed its attention on reducing waiting times of all the cancer patients. The NHS cancer plan 2000 lays out the ways of improvement. By 2008, the ultimate target was that no patient should wait longer than one month from an urgent referral by their GP for suspected cancer to the start of treatment.

Methods: Data regarding all cancer patients including breast, lung, upper and lower GI, skin, gynaecological, urological, head and neck, haematological malignancies, children's cancers, sarcomas and others in England were collected from the department of health records. All cancer patients treated during the period (Oct. 2007 to Oct. 2008) which fall under the category of one month wait target were counted.

This also included the total number of patients treated during the quarter by referral type i.e. urgent GP and other referrals in England. The data were analyzed using the excel spread sheets.

Results: Based on all the urgent GP referrals, 80% were received within 24 hours. The highest number of referrals were received for breast cancer followed by lower GI, skin, lung and head and neck cancers. The percentage compliance of 31 day target in these cancers was 98-99%.

The rest of 19% urgent referrals which were received after 24 hours had percentage compliance of 90% in 2007 and early 2008 but was noted to be improved to 94% in the last quarter of 2008. The referrals which did not meet the target were mainly dermatological followed by breast, lower GI, urological, gynaecological and head and neck.

Conclusion: Around 220,000 people are diagnosed with cancer each year in England, and the disease causes more than 128,000 deaths. The total number of new cases of cancer is increasing by 1.4% per year, as the UK's ageing population grows. The NHS Cancer Plan (2000) proposed that targeting 'cancer waiting times' and providing referral guidelines would lead to an improvement in the outcome of patients with cancer. The 31 day target is indeed a challenging target and it has certainly highlighted and focused on those patients who have been given the diagnosis so that the treatment could be initiated as quickly as possible.

After taking into account of the statistics, Better Cancer Care – An Action Plan was launched in October 2008. Two key and complimentary strands of this work are assuring compliance with national clinical standards and guidelines through robust clinical governance and delivery of two new cancer targets, one of which is 31-day target from decision to treat to first treatment for all patients diagnosed with cancer irrespective of their route of referral. These new targets have to be achieved from October–December 2011. The recommendations made to achieve the target are development and implementation of effective clinical pathways across organisational boundaries and sustainable delivery by continuous development of data management system so that resources are not diverted and data capture is complete and as robust as possible.

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POSTER

Epidemiology of Primary Brain Tumours in Georgia – First-year Results of a Prospective Population-based Study

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The aim of this study was to determine the incidence patterns of primary brain tumours.

Materials and Methods: A population-based cohort study of all patients diagnosed with primary brain tumours was conducted in Georgia from April 2009. Data from all neurosurgery as well as imaging departments of three large cities, which represent nearly all medical activities for people with intracranial neoplasms in the country, were collected and reviewed. Follow-up scan reports and tumour recurrence cases were excluded.

Results: After 1 year, 433 new cases were detected, males accounted for 40% of the cases. 38 cases were less than 20 years of age at the time of diagnosis (8.8%). Annual incidence rate adjusted to WHO world standard population was 9.87 per 100,000 individuals. Sixty percent of all tumours were diagnosed neuroradiologically. Non-malignant tumours accounted for 71% of all tumours (3.37 per 100,000). The most frequently reported histologies were predominately non-malignant: meningioma (46.2%, n = 108), followed by pituitary tumours (19.2%, n = 45). Among major histology groups, crude incidence rates were highest for tumours of the meninges (2.71 per 100,000), followed by tumours of the sellar region (1.21 per 100,000) and neuroepithelial tumours (1 per 100,000). Incidence rates by specific histology were highest for meningioma (2.46 per 100,000), pituitary adenomas (1.03 per 100,000), glioblastomas (0.34 per 100,000) and neurinomas (0.32 per 100,000). Glioblastoma accounts for the majority of glioma (51%). Crude rates of all major histology groups are higher among females than males.

Conclusions: This is the first study in the Caucasus region to define the incidence and the clinical and pathologic features of primary brain tumours based on current 2007 WHO classification. The observed low incidence rates compared with international published data may be explained by high percentage of unclassified tumours (46%), but might also be revised after more years of data become available.

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