definitive surgery to medical oncology assessment, and a higher rate of multiple operations. Potential strategies to reduce treatment delays for rural patients include the use of frozen section analysis of intra-operative sentinel nodes to reduce staged axillary dissections, minimising referral times to medical oncology by use of virtual multi-disciplinary meetings, improved efficiency in pathology reporting, and introduction of a breast cancer coordinator. Since delays in commencing chemotherapy are known to affect treatment efficacy, further resources are required to improve integration of rural surgical and medical oncology services.

Table: Time from surgery and medical oncology assessment to the commencement of adjuvant chemotherapy

Interval	Median time (weeks)			
	Rural cohort (n = 79)	Urban cohort (n = 94)	Difference (weeks)	p-value
Primary surgery to chemotherapy	8.9	4.3	4.6	<0.001
Definitive surgery to chemotherapy	6.3	3.9	2.4	<0.001
Primary surgery to definitive surgery (when multiple operations needed)	(n = 34) 3.9	(n = 23) 3.0	0.9	0.2
Definitive surgery to medical oncology assessment	4.9	1.9	3.0	<0.001
Medical oncology assessment to chemotherapy	1.4	2.0	−0.6	0.07

3620 POSTER

Use of Darbepoetin Alfa for the Treatment of Chemotherapy-induced Anaemia in European Clinical Practice − Data From the CHOICE Study

S. Van Belle[1], A. Galid[2], C. Karanikiotis[3], T. Wheeler[4], B. Pujol[5], J.L. Labourey[6]. *[1]University Hospital Ghent, Medical Oncology, Ghent, Belgium; [2]Hanusch KH, Gynecology and Obstetrics, Vienna, Austria; [3]Euromedica − Kyanous Stavros Hospital, Oncology, Theassaloniki, Greece; [4]Amgen Ltd, International Development, Uxbridge, United Kingdom; [5]Amgen Europe, International Development, Zug, Switzerland; [6]Centre Hospitalier Antoine Gayraud, Oncology/Haematology, Carcassonne, France*

Purpose: A final analysis from the CHOICE study to assess the percentage of patients (pts) treated with darbepoetin alfa (DA) according to its European product label.
Methods: A prospective, multicentre, observational study (EudraCT Number: 2007–007665−21) assessed DA use among 1,900 pts with cancer in 11 European countries. Haemoglobin (Hb) levels and red blood cell (RBC) transfusion requirements were evaluated.
Results: *Demographics*: A total of 1,887 pts (mean±SD age 62.4±11.4 yr) were included in the full analysis set. Cancer types included: lung (n = 701); breast (n = 575); colorectal (n = 310); and ovarian cancer (n = 301); 1,585 pts (84%) had a current disease stage of ⩾3. Common chemotherapy regimes were platinum based (n = 574 [30%]), taxanes (n = 316 [17%]) or a combination of both (n = 215 [11%]).
Haemoglobin levels: At DA initiation (baseline [BL]), 1,051 pts (56%) had a Hb value <10 g/dL. Mean Hb level was 9.8±0.8 g/dL at BL, which increased to 10.7±1.8 g/dL at the end of the treatment period (EOTP). Complete records for the primary outcome (proportion of pts with a Hb level between 10 and 12 g/dL at week [wk] 9) were available for 1,170 pts (62%). A total of 596 out of 1,887 pts (32% [crude percentage]) had a Hb value of 10−12 g/dL (95% confidence interval [CI]: 30%,34%), 239 pts (13%) had a Hb value >12 g/dL and 335 (18%) had a Hb value <10 g/dL. Of pts still on study at wk 9 (1,081 pts): 517 pts (48%) had a Hb value in the target range of 10−12 g/dL (CI: 45%,51%); 172 pts (16%) had a Hb value >12 g/dL and 279 pts (26%) had a Hb value <10 g/dL; data were missing for 113 pts (10%). For pts with a BL Hb level <10 g/dL, the Kaplan–Meier percentage (K-M%; wk 1 to EOTP) achieving Hb levels ⩾10 g/dL was 90% (CI: 75%, 104%) with 10% (CI: 7%, 12%) of pts having a Hb value >13 g/dL.
RBC transfusions: From wk 5 to EOTP, 18% (K-M%) of pts required RBC transfusions (only pts in the study for ⩾29 days after starting DA treatment; CI: 16%,20%). Among pts with a BL Hb value <10 g/dL or ⩾10 g/dL, 22% (K-M%; CI: 19%,25%) and 13% (K-M%; CI: 10%,16%) received RBC transfusions, respectively.
Adverse events: Eleven out of 1,887 pts (5 with BL Hb <10 g/dL; 6 with BL Hb ⩾10 g/dL) reported DA treatment-related adverse drug reactions (6 were thromboses).
Conclusions: In agreement with the European product label for DA, the majority of pts initiated DA treatment at a BL Hb level <10 g/dL. DA was effective in achieving the recommended Hb target range.

3621 POSTER

Assessing 2-month Clinical Prognosis in Patients With Solid Tumours − Final Results of PRONOPALL Study

H. Bourgeois[1], S. Traore[2], P. Maillard[3], M. Marcq[4], E. Boucher[5], E. Bourbouloux[6], J. Baudon[7], P. Mussault[8], P. Ingrand[9], F. Grudé[10]. *[1]Centre Jean Bernard, Medical Oncology, Le Mans, France; [2]Centre Paul Papin, Bio-Statistics, Angers, France; [3]Centre Paul Papin, Medical Oncology, Angers, France; [4]Hospital Center, Medical Oncology, La Roche sur Yon, France; [5]Centre Eugène Marquis, Medical Oncology, Rennes, France; [6]Centre René Gauducheau, Medical Oncology, Nantes, France; [7]Hospital Center, Medical Oncology, Cholet, France; [8]Hospital Center, Palliative Care Unit, Longjumeau, France; [9]University Hospital Center, Bio-Statistics, Poitiers, France; [10]Centre Paul Papin, Regional Health Agency, Angers, France*

Background: In 2008, we published our results of a prognostic score defined by 4 factors (Karnofsky index, number of metastatic sites, serum albumin and LDH levels) in a population of 177 hospitalized patients in two hospitals [1]. Albumin cutoff was 33 g/l and LDH cutoff was 600 ui/l. This score defined 3 different patients populations: A: low score (0 to 3), B: intermediate score (4 to 7) and C: high score (8 to 10). The survival rates at 2 months were 92.2±3.8% (population A), 42.7±5.2% (population B) and 8.3±4.6% (population C).
Methods: In order to validate this score with performance status (PS), we decided to start a second study in a large multicentric trial with a high proportion of out-patients.
Results: Between October 2009 and October 2010, 302 patients were included from 16 institutions. Inclusion criteria: adults patients with a solid tumour in palliative setting and with one or more of the three following criteria: life expectancy less than 6 months, PS ⩾ 2, evidence of progressive disease during palliative chemotherapy. All patients signed an informed consent. At this time, 146 (48%) patients are evaluable for this first analysis. 13 patients are not eligible. Median age 64 years [37−87], women 60%, men 40%. PS 0−1 (43%), PS 2 (40%), PS 3−4 (17%). The most frequent primary sites: breast (39%), colon/rectum (23%), lung (15%), pancreas (10.5%), others (12.5%). One metastatic site (31%), two (37%), more than two (33%). Median LDH level: 362 ui/l [118–1314]. Median level of serum albumin was 36 g/l [20−54]. According the prognostic score, the 2-month survival rate and the median survival were 87% and 306 days [195–417] (population A, 72 patients), 60% and 75 days [53−97] (population B, 62 patients) and 18% and 15 days [7−23] (population C, 12 patients). These three populations are statistically different (p < 0.0001).
Conclusions: PRONOPALL confirms the three prognostic profiles defined by combination of these four factors and is useful in daily practice.

References

[1] Assessing 2-Month Clinical Prognosis in Hospitalized Patients With Advanced Solid Tumours. Anne-Claire Barbot, Pascale Mussault, Pierre Ingrand and al. J Clin Oncol vol 26, p 2358–2543; 2008.

3622 POSTER

Audit Programmes Can Actually Improve Cancer Control

M. de Boer[1], A. Nuijten[1], R.J. Oostenbroek[1]. *[1]The Dutch Comprehensive Cancer Centre Rotterdam, Oncology, Rotterdam, The Netherlands*

Background: The purpose of IKNL is to provide cancer patients and their families access to comprehensive and high-quality care, as close to home as possible. This service is directed towards improving professional, organisational and relational quality of oncology care. The Rotterdam area has 15 general hospitals and a university hospital. In 1996 an audit programme started to monitor and improve the quality of care in the general hospitals. Until 2011 these hospitals have been audited three times, the third started in 2008. After each round the focus was reassessed and has shifted from monitoring the organisation of care to measuring quality of care outcome with performance indicators. We evaluated the quality of care, the audit process and the perceived benefit of performing audits. In 2011 an comparable audit program in the whole country was started.
Material and Methods: The audit program concentrates on structure and process criteria. The auditing committee is peer based. The final audit report reflects the number of criteria and contains recommendations for improvement. The audit reports of these hospitals were analysed, comparing results in first, second and third round. The committee and hospital management received a questionnaire to evaluate the benefit of oncology audits. The auditing process itself was continuously evaluated and optimized with the Plan-Do-Check-Act cycle especially in the third round.
Results: In all 15 hospitals, results on the audit criteria improved between the rounds. The remaining major issues are the poor availability of performance indicators as perceived by the professionals and the poor