was median 23 days (range 12−54) for both cycles. The recovery time was median 10 days for neutrophils and 11 days for platelets in both cycles.
Conclusions: The SWENOTECA IV HDCT strategy resulted in a favorable outcome within a population-based cancer care program. Furthermore, toxicity and hospitalization did not differ between the first and the second HDCT cycle.

7112 POSTER DISCUSSION

Early Diagnosis of Androgen Deprivation Syndrome in Testicular Cancer Survivors − an Audit of 1155 Patients in the West Midlands

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Background: Testicular cancer (TC) is a curable malignancy in the majority of the patients. A minority of TC survivors develop androgen deprivation syndrome (ADS) with vague symptoms that are not always appreciated. This study refers to TC survivors in the West Midlands, who were diagnosed with ADS and started with androgen replacement treatment (ART) at the University Hospital Queen Elizabeth Cancer Centre.
Materials and Method: The details of patients started on ART during the last 11 years were retrieved from the disease specific data-base and cross-matched with the hospital records. For each patient, we recorded the following: Demographics, age at diagnosis, single or bilateral orchidectomy, site and stage at presentation, histology, treatment details, relapse, Testosterone/FSH/LH assessment, date of first reported symptom, type of symptoms, time interval since diagnosis, time Interval between 1st symptom and 1st prescription of ART, age at 1st prescription, type and efficacy of ART.
Results: A total of 88/1155 (7.61%) patients with history of TC were started on ART during the last 11 years at the QE cancer Centre. The majority of patients (82/88) were diagnosed with ADS since 2006 as the level of clinical suspicion and vigilance increased. The median age of patients who were offered ART was 39 yrs (min 17, max 74). Patients with bilateral orchidectomy (BO:40/88) were started at the time of 2nd surgery before they developed symptoms. Patients with single orchidectomy (SO:48/88) reported at least 1 of the following prior to ART: lethargy 43/48, loss of libido 33/48, shaving pattern change 20/48, other: weight gain 4/48, mood change/depression 3/48, and headaches 3/48. The median level of Testosterone before ART was 8 nmol/L (range 0.5−23 nmol/L). The majority of patients had elevated LH/FSH prior to developing symptoms. The majority of patients (38/48, 79.1%) had clinical benefit from ART. None of the patients has been diagnosed with prostate cancer so far.
Conclusion: ADS is an under diagnosed entity which may occur to relatively young patients with history of TC within the first 5 years of follow up. ART is generally successful and improves symptoms in the majority of patients.

Histology		
Total	88	
Pure seminoma	57	
NSGCT	22	
Combined	6	
Leydig	3	
Bilateral orchidectomy or atrophic/non existent testis, 40/88	started ART with 2nd surgery	
Single Orchidectomy (SO), 48/88		
Treatment post SO	Carboplatin AUC7	20
	Surveillance	3
	Other (BEP,TIP,EP)	28
From TC diagnosis to 1st symptom	14.96 mo	
From symptom to 1st T level	1.32 mo	
From TC diagnosis to ART	16.67 mo	
Clinical benefit with ART (SO)	Improved	38
	Lost to FU	2
	No benefit	2
	Stopped	2
	Unsure	4

7113 POSTER DISCUSSION

FGF-mechanism of Resistance to VEGF Receptor Antagonists

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Background: The growth of new blood vessels is regulated at multiple steps by interactions between several pro- and antiangiogenic factors. We believe that the angiogenesis induced by basic fibroblast growth factor (bFGF) is resistant to anti-VEGF/R (vascular endothelial growth factor/receptor) therapy.
Methods: The Corneal Micro Pocket Assay was performed. 70 female C57BL/6 mice (age at start day, 6 weeks) were randomized to 7 arms (10 mice in each group): 1) bFGF; 2) VEGF-A; 3) bFGF negative, VEGF-A negative; 4) bFGF and sunitinib; 5) VEGF-A and sunitinib; 6) bFGF and bevacizumab; 7) VEGF-A and bevacizumab. Doses of bFGF, VEGF-A (R&D Systems), sunitinib (Pfizer), and bevacizumab (Roche) were 200 ng, 400 ng, 10 mg/kg, 50 mg/kg per animal, respectively. Hydron pellets preparation, surgical procedure, and quantification of angiogenesis (angiogenic score) were performed as previously reported (Kenyon BM et al.). Statistical significance was determined by the Student's t test.
Results: There was no neovascularization in bFGF negative, VEGF-A negative group (mean, 0). The effect of 200 ng/pellet of bFGF (mean, 4.2; SEM, 0.05) was compared with that of 400 ng/pellet VEGF-A (mean, 4.08; SEM, 0.09), P = 0.7. In bFGF-induced angiogenesis, sunitinib (mean, 3.9; SEM, 0.1; P = 0.2) and bevacizumab (mean, 4.71; SEM, 0.33; P = 0.85) did not impact on neovascularization in comparison with bFGF positive control. The angiogenic effect of VEGF-A was significantly inhibited by both sunitinib (mean, 0.38; SEM, 0.06; P = 0.001) and bevacizumab (mean, 0.75; SEM, 0.05; P = 0.001) in comparison with VEGF-A positive control. No significant differences between 2 targeted agents in bFGF and VEGF-A models were obtained.
Conclusion: Our recent findings demonstrate that anti-VEGF(R) therapy significantly impacts on VEGF-A-induced angiogenesis and not on bFGF-induced neovascularization. Further studies are needed to assess the role of FGF-pathway in resistance to VEGF(R) therapy.

7114 POSTER DISCUSSION

Appropriateness of Treatment Options for the Management of Patients With Advanced Renal Cell Carcinoma (RCC) Using the Validated Semi Quantitative RAND Corporation/University of California, Los Angeles (RAND/UCLA) Methodology

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Background: Targeted therapies have radically improved the outlook for patients with advanced RCC. A number of factors contribute to treatment choice such as prior treatment and prognostic risk assessment (e.g. MSKCC risk criteria). In order to combine up-to-date clinical evidence with the experience of experts in the field, we have undertaken an update of prior work to include newer treatments and evidence, and add a European perspective.
Methods: The RAND/UCLA method was employed using a panel of 11 EU experts. Cases and treatments were grouped according to clinical patient scenarios. Individual panel members scored the appropriateness and their preferences of several interventions for each case and treatment, 1 (inappropriate) to 9 (most appropriate). This was followed by a panel meeting to reconcile disagreements as per the RAND methodology.
Results: There was excellent concordance among the panel for the appropriateness/inappropriateness of therapies for the majority of different clinical scenarios considered with only 4.2% disagreement. There were however a number of areas where the preferences or opinions of panel members varied ("disagreement"). Two such examples were

- Use of sunitinib or pazopanib in two instances, patients with locally advanced tumour and those with metastatic disease and the primary tumour in-situ, with good surgical risk and no prior systemic therapy but with high risk features (MSKCC criteria)
- Use of temsirolimus in papillary and oncocytic carcinoma