associated with morbidity. The low mortality rate observed reflects that moderate/major cancer surgery is feasible in elderly. Further participation from other centre is welcome.

1256 ORAL

The "Comprehensive Geriatric Assessment" (CGA) is an effective instrumental tool for therapeutic decision making and clinical outcome in elderly cancer patients

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The aim of this study was twofold. The first aim was to verify the correlation between the single instruments of CGA and the most significant variables of neoplastic disease (stage, ECOG). At May 2005, 209 patients (mean age 72.4 years; range 65–93) with cancer at different sites have been evaluated at baseline using the CGA. The Spearman's correlation test has highlighted a correlation of: 1) cognitive function (evaluated with MMSE) with PS ECOG ($p < 0.001$), 2) age with IADL ($p < 0.0009$), 3) age with PS ECOG ($p < 0.006$). The second aim was to verify the feasibility of using the CGA as an effective instrumental tool for therapeutic decision making and clinical outome in elderly cancer patients. A prospective study was designed in July 2004 and it is currently underway.
The therapeutic decision making was based on the patient assignment to the following 3 groups: 1) "fit" patients were assigned standard chemotherapy as for adult patients, 2) "intermediate" patients were assigned tailored (chemo) therapy, 3) "frail" patients were assigned monochemotherapy (as "supportive therapy") or only "supportive therapy". At May 2005, 35 patients were enrolled: mean age 74.0 years, range 65–82, M/F 20/15. Thirteen patients are currently evaluable, 7 are currently under treatment and are too early to be assessed and 15 received only supportive therapy and died early. Four out of 13 evaluable patients were "fit", 5 "intermediate" and 4 "frail". As for protocol the 4 patients "fit" completed the standard chemotherapy treatment and the outcome was as follows: 1 CR, 2 PR and 1 SD. The 5 patients "intermediate" completed tailored chemotherapy: 1 is NED, 2 SD and 2 PD (1 alive and 1 dead). Three out of 4 patients "frail" received "supportive chemotherapy" and 1 only radiation therapy: all patients completed the treatment and the outcome was: 1 SD and 3 PD (1 alive and 2 dead).
Comprehensively, 10 out of 13 evaluable patients are alive and 3 are dead. The median follow up duration was 5 months. The terapheutic choice based on CGA assessment has shown to be effective in terms of clinical outcome and particularly patient compliance: indeed, only 1 patient had to reduce the dose of the scheduled therapy due to toxicity. Further on in the study it will be interesting to make a comparison between the 3 groups in terms of clinical outcome as well as patient compliance. The study is in progress.
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1257 ORAL

Factors determining the treatment plan for early breast cancer patients aged 70+: an audit of patients at Southend General Hospital, UK.

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Aim: to evaluate factors determining the treatment of early breast cancer patients aged 70+, and to assess acceptability and tolerability of chemotherapy (CT), in anticipation of activating the proposed Adjuvant Cytotoxic Chemotherapy In Older Women (ACTION) trial.
Method: Patients diagnosed between 01/04/2004 and 30/09/2004 were identified from Multi Disciplinary Meetings and Surgical Department records. Demographic, pathological and treatment data were collected for all patients. Toxicity data were collected for patients receiving CT. Univariate analyses (Fisher exact tests and T tests) of clinical prognostic factors and other demographic features were carried out to identify factors associated with treatment plan.
Results: 58 eligible patients were identified, of whom 40 (69%) had primary surgery. Of these, 14 (35%) were offered CT (4 cycles of 3 weekly AC, as per proposed ACTION trial). 7/14 (50%) patients accepted CT.
Lower age was significantly associated with receiving primary surgery (mean age (SD) 77.2yrs (4.5) vs 82.9yrs (7.1); $p = 0.005$), being offered CT (mean age (SD) 75.7yrs (4.2) vs 79.8yrs (6.1); $p = 0.02$) and accepting CT (mean age (SD) 72.8yrs (2.2) vs 78.6yrs (3.8); $p = 0.005$). Patients with Grade 3 tumours were more likely to be offered CT, (11/14 [79%] vs 7/44 [16%] $p > 0.001$). ER negative status was not strongly related to being offered CT (7/14 [50%] vs 34/44 [77%]; $p = 0.09$). There was no association between receiving surgery and living alone (18/40 [45%] vs 12/18 [67%] $p = 0.13$). However, living alone was strongly associated with being offered CT (3/14 [21%] vs 27/44 [67%]; $p = 0.01$) but not with accepting it (1/7 [14.3%] vs 2/7 [29%]; $p = 1.00$), however this is based on very small numbers. The association with living alone and offering CT was not confounded by age as the association remained after adjustment for age ($p = 0.03$) There was no association between pathological tumour size or comorbidity and patients receiving surgery, being offered CT or accepting CT.
All 7 patients who accepted chemotherapy received 100% dose intensity and none experienced grade 3/4 toxicity (age range 70–77).
Conclusions: Although the number of patients receiving CT was small, this audit offers encouraging data on the toxicity profile of the CT regimens in the proposed ACTION trial. Factors most likely to limit recruitment are age and failure to undergo primary surgery, however failure to undergo surgery is strongly associated with greater age.

1258 ORAL

Renal insufficiency in cancer patients: Prevalence and implications for anticancer drugs management. Preliminary results of the "IRMA" study

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Background: Only few data are available on the prevalence of renal insufficiency (RI) in cancer patients. Since approximately one half of anticancer drugs are predominantly excreted in the urine, dosage adjustment of those drugs in such patients is a crucial issue. The IRMA study (Insuffisance Rénale et Médicament Anticancéreux) was thus started in March 2005 to investigate the prevalence of RI in cancer patients and the profile of the anticancer drugs they received.
Material and methods: Data were collected for in- and outpatients with cancer presenting over two periods of time (February 1st-15th and October 1st-15th, 2004): sex, age, weight, serum creatinine (S_{CR}), serum urea nitrogen, serum albumin, measured creatinine clearance, measured glomerular filtration rate (GFR) when available, type of tumour, bone or visceral metastasis yes/no, anticancer drugs and dosages. Dialysis and myeloma patients were not included. 1435 patients were included from 5 anticancer centres. The prevalence of S_{CR} >110 μmol/L was estimated. Cockcroft-Gault GFR was calculated with and patients were classified according to their calculated GFR and the K/DOQI stages of RI: 1: GFR ⩾90 mL/min, 2: 60–89, 3: 30–59, 4: 15–29. Among anticancer drugs prescribed, those necessitating dosage adjustment were identified according to their pharmacokinetics and available recommendations from the literature and their SmPCs. Drugs for which there were no data available were labelled as "necessitating dosage adjustment".
Results: The prevalence of elevated S_{CR} (>110 μmol/L) was 5.3%. The prevalence of decreased GFR in those cancer patients was 62.8%. There were a total of 2386 prescriptions on 53 different drugs (INN). Two-third of the drugs needed dosage adjustment (69.8%), representing half the total number of prescriptions (54%). Finally, almost three-quarters of the patients (72.3%) were receiving at least one drug for which dosage adjustment was mandatory in patients with RI.