**Methods:** In response to a huge surge in contacts via various media (telephone, letter, fax and e-mail) following the announcement of the results of the adjuvant Herceptin trials published in October 2005, our department decided to hold a series of public meetings throughout the locality to explain the trial data and to inform of the local and national position in respect of Herceptin use.

Meetings were heavily publicised in all the local media. Core members of the local multidisciplinary team responsible for breast cancer services gave short presentations followed by open question and answer sessions. Using the media, questions were also invited in advance of the meetings by phone, e-mail or fax.

**Results:** An audit of the number of enquiries received in the days before the meeting and immediately after showed an 80% reduction; attendees also rated the meetings as "useful" or "very useful" in 93% of those completing them. The initiative was also welcomed by the local health service providers and other parties.

Units faced with similar acute demands for information should consider this method of addressing them; our own unit is considering extending their role and frequency.

This is an ongoing project and further information about outcomes is expected.

**144** Poster

**Prospective audit data collection in the Adelaide and Meath hospital incorporating the National Childrens Hospital, Dublin**

T. Duffy[1], M. Atkinson[2], J. Geraghty[3]. [1]*AMNCH, Breast Unit/Department of Surgery, Dublin, Ireland;* [2]*AMNCH, ICT, Dublin, Ireland;* [3]*AMNCH, Department of Surgery, Dublin, Ireland*

**Introduction:** The Adelaide and Meath Hospital incorporating the National Childrens hospital, Dublin (AMNCH) has implemented the Dendrite system for audit of cancer data. The system currently covers Breast, Upper GI, Urology and Colorectal cancers with imminent expansion to other areas.

**Hypothesis:** Traditionally Data Managers have entered data into registries retrospectively. [Registry is defined as information relating to a particular anatomic area within the Cancer Audit System (i.e. Breast Registry, Colorectal Registry)]. This results in substantial delays in the availability of information for audit. In order to maximise the use of our Cancer Audit System [Dendrite Patient Analysis and Tracking System] within the clinical area we have integrated the use of the audit system into the daily clinical practice. Clinicians, Nursing staff and Database Managers record clinical data at the point of contact with the patient (or soon afterwards) to ensure that an up to date registry is available for audit.

**Method:** The point of initial capture of patient information was identified. Where possible we eliminated duplication of data capture through:

- Interfacing the audit system with existing hospital applications.
- Direct entry by clinical staff with print-outs for filing in patient records.
- Collection of data in a format readily transferable to the audit system.

**Results:** Over 80% of the 656 basic fields [field count excludes pathology and follow-up information] in the Breast Registry are captured in a single data capture step by the medical staff in the Breast Unit. A further 5.49% of data are automatically pulled into the audit system through interfaces.

In total 90% of the data entered into the registry is captured at the point of contact with the patient. This warehouse of data is accurate, of high quality and readily available for clinical audits and research purposes.

**Conclusion:** We believe that prospective data collection is a valuable addition to the audit function. Time constraints on medical staff ensure that the single step process is streamlined and utilised only where additional value may be gained by direct collection of data. In AMNCH we have ensured added value through the utilisation of extensive reports and outputs which replace handwritten notes in the patients' charts. The resultant familiarity with data collected acts as a driver for interrogation of the database for research.

**145** Poster

**Computerising a rapid breast clinic**

M. Atkinson, T. Duffy, J. Geraghty. *Adelaide & Meath Hospital, Department of Surgery, Dublin 24, Ireland*

**Introduction:** The Adelaide & Meath Hospital, Dublin Incorporating the National Children's Hospital (AMNCH) runs a weekly Rapid Diagnostic Breast Clinic. The purpose of this clinic is to provide an efficient, patient centred, service for women with a suspected breast cancer. The ability to audit is critical in the provision of a targeted and effective service. A database was developed with the ICT Department for use by the Rapid Breast Clinic to enable electronic collection of clinical data.

**Hypothesis:** We believe that the audit process itself will be cost effective, as a result of implementing a single data capture step.

**Method:** The database was developed using Key Extra which is a module of Order Comms. The system is integrated to PIMS, which automatically captures patient demographics. The clinic is fully computerised with doctors entering clinical data directly onto the system during patient consultations. A patient report is printed following consultation, signed, and placed in the patient's chart.

**Results:** The system was successfully implemented in 2003 and the clinic is now fully computerised. Data required for auditing is retrieved using Business Objects (statistical software) which enables the Breast Unit to examine how efficient the services they provide are. There is a 43% cost saving in using the IT system for auditing as there is no longer time spent manually processing records for auditing purposes.

**Conclusion:** Computerising the clinic has resulted in major benefits to the service provided by the Rapid Breast Clinic through the availability of accurate and timely data which can facilitate clinical performance and development of protocols.

**146** Poster

**Under-representation of ethnic minorities in clinical trials of patients with breast cancer: the United Kingdom experience**

S. Pollard[1], V. Hiley[1], M. Lansdown[2]. [1]*University of Leeds, CTRU, Leeds, United Kingdom;* [2]*St James's University Hospital, Leeds, United Kingdom*

There is a lack of participation in clinical trials by ethnic minorities [1].

Within this study we looked specifically at recruitment into three adjuvant breast cancer trials taking place between 1996–2005 (see table).

Summary of recruitment into three adjuvant breast cancer trials

| Trial | Recruitment | | | | |
|---|---|---|---|---|---|
| | Period | Total, UK | From ethnic minority groups | | Median age of pts recruited |
| | | | No. pts | % | |
| A | 1996–2000 | 3228 | 37 | 1.14 | 64 |
| B | 1998–2002 | 794 | 10 | 1.25 | 62 |
| C | 2003–2005 | 1977 | 75 | 3.8 | 52 |

In the two trials recruiting up to the year 2002 (trials A and B) 47 patients recruited belonged to an ethnic minority classification (Asian, Black, Oriental, other). This equates to 1.1% of total recruitment.

In the more recent trial (trial C), 75 patients belonged to an ethnic minority classification, equating to 3.8% of total recruitment. The figure from this trial appears to show an increase in ethnic minority participation in comparison to the earlier trials. However, the census from 2001 indicates that ethnic minorities account for 7.9% of the UK population and therefore there is still apparent under representation, even in current adjuvant trials, with a younger patient population.

Differences in median ages and the incidences of breast cancer between Caucasian and non Caucasian women are unlikely to explain the poor recruitment of women from ethnic minorities into clinical trials. Measures of absolute effectiveness, absolute harm and cost-effectiveness are associated with underlying risk levels in different socio-demographic groups. Under-representation will therefore bias absolute effect estimates.2

The issue of exclusion from trials of ethnic minorities has been relatively neglected in the UK research community and we need to investigate further why we are failing to recruit non-Caucasian women to breast cancer trials and to develop effective strategies for ethnic minority participation in clinical trials. 3

**References**

[1] Mason S, Hussain-Gambles M, Leese B, Atkin K, Brown J. Representation of South Asian people in randomised clinical trials: analysis of trials' data. BMJ 2003; 326: 1244–55.

[2] C Bartlett, L Doyal, S Ebrahim, P Davey, M Bachmann, M Egger and P Dieppe. The causes and effects of socio-demographic exclusions from clinical trials. Health Technol Assess 2005; **9**(38): 1–1683.

[3] M Hussain-Gambles, B Leese, K Atkin,J Brown,S Masonand P Tovey Involving South Asian patients in clinical trials. Health Technol Assess 2004; **8**(42): 1–124.