for CRC cancer pts) and prevention of a Hb decrease (67% for breast cancer vs 46% in CRC pts). Hb levels significantly increased in both cancer groups (see table). In 20% of the breast cancer pts and in 18% of the CRC pts, the treatment was discontinued due to patient Hb levels ⩾13 g/dl. Approximately 20% of the pts received RBC transfusions.
QoL improved in about half of the examined pts as judged by the physicians and emphasized by significant changes in FACIT-F and LASA scores (see table).
Conclusions: CRC and breast cancer pts with CIA receiving DA treatment experienced significant increases in Hb levels. In these patients, QoL also significantly improved as measured by the physicians' judgement and objective QoL scores. These data further support the effectiveness of DA treatment for CIA.

	Breast cancer (N = 574)		CRC (N = 222)	
Hb level (g/dl, mean±SD)				
Baseline	10±0.9		9.7±0.7	
End of correction phase	11.3±1.4		11.3±1.5	
Hb increase	1.3±1.4**		1.6±1.4**	
Treatment				
DA treatment duration (in weeks, mean±SD)	6.2±5.1		7.5±5.1	
Number of pts receiving RBC transfusions during treatment	100 (17%)		54 (24%)	
Number of pts receiving iron supplementation (intravenous and/or oral)	157 (27%)		78 (35%)	
QoL (mean±SD)	**FACIT-F**	**LASA**	**FACIT-F**	**LASA**
Baseline	97.6±28.1	46.1±26.4	95.9±25.5	44.2±25.2
End of treatment phase	104.8±26.9	39.1±24.2	101.0±28.2	38.1±24.1
Difference	7.3±21.5**	−7.2±23.4**	5.8±17.4**	−6.1±20.7*

*P < 0.01; **P < 0.0001 (Wilcoxon, paired).

This observational study was conducted by Amgen GmbH.

3035 POSTER

Distress Thermometer (DT) in multidisciplinary management of cancer patients (pts): quality of life and quality of care

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Background: Cancer involves all areas of patient's life and his family. To detect patients' needs at diagnosis is important to take care of him, recognize areas of major discomfort to improve his quality of life. The NCCN guidelines suggested the use of the DT since 2006, although others have questioned the real efficacy of this tool (Jacobsen JCO 25; 452−6; 2007).
Patient and Methods: Since 2007, 320 pts at diagnosis have filled in a self-evaluation thermometer that analyzes the distress through a numeric graduating scale (0−10). Five areas were explored to identify the causes for distress, according NCCN DT: physics, psychological, social, family and spiritual. If score was of 3 or more, pts were referred to an operator to whom was shown the cause of major distress observed. Median age of pts was 63 yrs (range 18−93), 55% female; 28% affected by gastrointestinal cancer, 18% breast, 18% genitourinary tract, 11% gynecologic, 8% lung, and 17% others.
Results: Average grade of distress has been 5. There haven't been observed substantial differences among the two genders, cancer type and comparative analysis between pts age < or >65 yrs, except for the prevalence of the second aspect: emotional in men (9%) and social in women (5.3%). Table shows the areas and the main aspect of distress in each areas.

PHYSICAL	**51%**	**EMOTIONAL**	**33%**	**SOCIAL**	**10%**
Gastrointestinal disorder	13%	Worry	35%	Transportation	33%
Fatigue	12%	Anxiety	21%	Financial	20%
Pain	9%	Sadness	16%	Housing	18%
Sleep	7%	Fear	15%	Child care	17%
Others	59%	Depression	13%	Others	12%
SPIRITUAL	**3%**			**FAMILY**	**3%**

Eighty-two% of pts has pointed more than one areas of distress (40% two, 27% three, 11% four and 4% five).
Conclusions: Our experience suggests that the DT is able to detect more than 45% of the pts' discomfort at diagnosis which is not detectable with a medical checkup. The inclusion of a psychologist and a social worker into the medical staff could guarantee a preliminary action in order to facilitate the therapeutic path. We have started a new randomized study in which the DT will be repeated after 3 and 6 months from the first time in order to evaluate whether supportive action has or not improved the distress.

3036 POSTER

G-CSF use and neutropenic events in patients with breast and lung tumours: data from routine clinical practice (IMPACT Solid study)

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Background: EORTC guidelines recommend primary prophylaxis with granulocyte colony stimulating factors (G-CSFs) for cancer patients at high overall (⩾20%) risk of febrile neutropenia (FN) due to chemotherapy (CT) and other risk factors, as well as to support dose dense regimens. We aim to assess G-CSF prophylaxis in clinical practice and its impact on neutropenic events and CT delivery.
Methods: This prospective, observational study (Clinicaltrials.gov: NCT00883181), is planned to include ~1300 patients with solid tumours (breast cancer, non-small cell lung cancer [NSCLC], small cell lung cancer [SCLC] and ovarian cancer) receiving any myelotoxic CT, who are judged to be at ⩾20% risk of FN per EORTC guidelines. The primary outcome measure is the incidence of FN in relation to G-CSF use.
Results: This descriptive interim analysis includes 202 patients recruited from Dec 2007, who completed CT by Dec 2008. The most common CT regimens in breast cancer were docetaxel (Doc)/doxorubicin (A)/cyclophosphamide (C) (22%), fluorouracil (F)/epirubicin (E)/C−Doc (18%) and A or E/Doc (17%), as was cisplatin + etoposide or vinorelbine in lung cancer (46%). G-CSF prophylaxis and FN events are shown below (see table).
Conclusions: This interim analysis suggests that many breast cancer patients considered at high FN risk are receiving aggressive adjuvant CT, often with G-CSF primary prophylaxis. The low proportion of elderly breast cancer patients suggests that few receive aggressive CT. Lung cancer patients may be at high FN risk due to older age and advanced disease. G-CSF primary prophylaxis was less common in this group, where FN and CT dose reductions were more frequent. Guidelines on G-CSF use may not be routinely applied in the non-curative setting. This ongoing study will help to better describe neutropenia management in clinical practice.

	Breast Cancer (N = 129)	NSLC (N = 39)	SCLC (N = 22)
Age, median (range)	50 (28−82)	65 (41−83)	62 (43−79)
Age ⩾65 years	17 (13%)	20 (51%)	6 (27%)
Advanced disease†	19 (15%)	34 (87%)	14 (64%)
ECOG performance status 0−1	128 (99%)	29 (74%)	16 (73%)
Pegfilgrastim primary prophylaxis*	79 (61%)	3 (8%)	1 (5%)
Daily G-CSF primary prophylaxis*	11 (9%)	5 (13%)	4 (18%)
FN in any cycle	14 (11%)	7 (18%)	1 (5%)
FN in cycle 1	11 (9%)	5 (13%)	0
CT dose delay >3 days in any cycle	33 (26%)	10 (26%)	6 (27%)
CT dose reduction ⩾15% in any cycle	16 (12%)	9 (23%)	4 (18%)

*From cycle 1; initiated by day 7 if CT given on Day 1 only or by day 11 if CT given on Day 1+8. †Stage IV (breast cancer), IIIb-IV (NSCLC) or extensive disease (SCLC). Ovarian cancer not shown (N = 12).

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3037 POSTER

Development of the Analgesic Quantification Algorithm (AQA): a new scale to assess changes in analgesic use

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Background: Approximately two-thirds of patients with advanced cancer experience pain and, of these, more than one-third rated their pain as moderate or severe. Consequently, assessing changes in pain has become an important focus for clinical trials of medications for cancer treatment that are expected to have an impact on pain. In order to better understand the