in the GC-I arm (80% vs. 50%; P = 0.07). This trend is more prominent for the non-hematological grade 3−4 toxicity (26% vs. 4%). Using the EORTC QLQ-C30 questionnaire, a moderate improvement was seen in the global health status and small to moderate in the functional scales (physical, role, emotional, cognitive and social) in the GC-I arm. There was no difference in the symptom scales between two arms. In the QLQ-LC13 questionnaire small to moderate improvement was seen in dyspnoea, coughing, haemoptysis and peripheral neuropathy favor the GC-I arm.
Conclusion: The preliminary results of this study warrant further investigation of iscador as modifier of side effects induced by CG in NSCLC patients.

3045 POSTER

A two-day rapid outpatient diagnostic program decreases anxiety in suspected lung cancer patients

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Background: Anxiety and depression are common in lung cancer patients. The diagnosis can be a major cause of distress but there is little information about the influence of delay and type of diagnostic pathway. The purpose of this pilot study was to evaluate anxiety, depression and quality of life in patients with suspected lung cancer in a complete two-day rapid outpatient diagnostic program which includes consultation of a chest physician, thoracic CT-scan combined with (18)fluoro-deoxyglucose positron emission tomography (FDG-PET-scan), pulmonary function tests, bronchoscopy and disclosure of the cytology results on the second day.
Materials and Methods: Patients referred for evaluation of a suspicious lesion on chest X-ray completed the Hospital Anxiety and Depression Scale (HADS) and Euroqol EQ-5D on the first day before consultation (T1), the day after the program (T2), and one week after T2 (T3). Patients were divided into 2 groups. Group A knew the diagnosis on T2 (benign or malignant), group B at T3 or later. Patients with benign and malignant diagnoses were also compared.
Results: 19 patients (mean age 63, range 40−84) participated; 12 in group A, 7 in group B. HADS-anxiety scores did not differ significantly between groups at T2 (6.9 and 8.1), but did at T3 (6.0 and 10.4, p 0.04). Patients in group B had a deteriorating general quality of life (QOL) score to a mean of 43% as measured by Euroqol (p 0.055). HADS-depression scores did not differ significantly. When divided into having benign, malignant or not yet any results HADS-anxiety scores showed a significant interaction effect of time x group ($p < 0.05$). Patients with benign results (n = 4) showed a sharp decrease in anxiety scores (8.8, 7.0 and 4.8), patients with malignant results at T2 (n = 8) had steady anxiety scores (5.6, 6.9 and 6.9) but patients with malignant (n = 2) or still unknown diagnosis at T3 (n = 5) increased to 10.4 at T3. HADS-depression scores had the same pattern but the effect did not reach statistical significance (p 0.08).
Conclusions: This pilot study shows that patients with suspected lung cancer have very high mean anxiety scores, which increase even further in case of prolonged uncertainty, and decrease in case of benign disease. A rapid diagnostic program might decrease the amount of time spent in anxiety and improve QOL. To test this hypothesis we have started a multicenter study, following suspected lung cancer patients in both usual diagnostic care and rapid programs during 6 weeks with more eleborate weekly questionnaires.

3046 POSTER

Interventions by dieticians in oncologic hospitalized patients

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Malnutrition is defined as a deficit in intake and/or absorption of sufficient energy and proteins. It is prevalent in cancer patients, but malnutrition and intervention to correct malnutrition are undervalued. Malnutrition leads to a higher morbidity, higher mortality, longer hospitalization and higher cost. In the Ziekenhuisnetwerk Antwerpen (ZNA)-Middelheim, several nutritional interventions have been developed to detect malnutrition and to give nutritional support: screening of all hospitalized patients for malnutrition; measures to improve or conserve nutritional status, limiting weight loss, and nutritional support in patients with cancer-and treatment-related complications. To this aim, a nutritional anamnesis is performed, anthropometric parameters are collected and the nutritional need is calculated. An individual nutritional plan is constructed in cooperation with the patient according to the schedule mentioned in the Table.

Table: nutritional plan

	Energy (kcal)	Protein (g)	Vitamin & mineral
Nutritioneal need	2000	68	OK
2/3 + 3 meals in between	2075	66	OK
2/3 + 1 protein replacement	1850	70	OK
2/3 enriched + 1 protein-rich replacement	2325	76	OK
1/2 enriched + 1 protein-rich replacement	1810	60	OK
1/2 + 1 liter isocaloric tube feeding	2095	74	OK
1/3 enriched + 2 protein-rich replacement	1770	68	OK
1/3 enriched + 1 liter isocaloric tube feeding	2170	68	OK

To evaluate the program, a prospective registration was performed in oncologic patients hospitalized at the department of Hemato-oncology of the ZNA-Middelheim.
Between 1/11/2008 and 30/11/2008, 63 patients (36 men; 27 women) were hospitalized at the department. Most patients were suffering from head and neck cancer (23.8%), hematologic malignancies (23.8%) and gastrointestinal cancer (19%).
Of these 63 patients, 68.3% (n = 43) were visited by a dietician and in 79% (n = 34) a nutritional intervention was performed (adaptation food (n = 11); enrichment (n = 7); nutritional supplements (n = 2); enrichment and nutritional supplements (n = 12); tube feeding (n = 3); tube feeding + enrichment (n = 1)). There was no difference in interventions among patients with hematologic, head and neck and gastrointestinal cancer.
In this prospective registration, 68.3% of the patients were visited by a dietician and 79% of them received a nutritional intervention, showing the importance of the dietician in the multidisciplinary oncologic team.

3047 POSTER

Cancer patients' attitudes on smoking, quitting and total ban at cancer hospitals

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Background: Apart from being one of the major causes of cancer, tobacco smoking can affect cancer treatment and prognosis as well.
In Serbia, hospitals should soon become completely smoke-free. However, there is a dilemma if some types of wards (oncology, psychiatry) should be exempted. Cancer patients are suffering from severe stress, various symptoms and disabilities, long hospital stay. This situation might motivate them quit smoking or, on the contrary, smoking ban could be an additional stress.
Materials and Methods: Group for cancer patients support has been established at the Institute for Oncology and Radiology of Serbia in 2007 by cancer patients and health care professionals in order to provide support to patients, advocate for their needs and improve communication with health care professionals.
This group initiated the survey among patients at the Institute in order to establish cancer patients attitudes on smoking, quitting and the total ban of smoking in cancer hospitals.
A one-day anonymous survey on attitudes on smoking, quitting and the total ban of smoking in hospital has been carried out among all hospitalized and daily clinic patients of the Institute for oncology and Radiology of Serbia.
Results: A questionnaire was completed by 316 cancer patients. Among them, 45% were never smokers and 26% former smokers. Two thirds of patients considered smoking very harmful for health, and 75% thought it was very important for cancer patients to quit smoking. Among patients with lung, laryngeal and oral cancer the percentage of never-smokers as well as the belief in harmfulness of smoking was lower.
Over 80% of all patients thought that the period of treatment at the Institute is the right moment to quit. The majority of patients supported the idea of smoking cessation courses organized for patients at the Institute. However, finally, only 49% of all patients supported the total ban of smoking at the Institute while 47% thought that rooms for smoking should be provided for patients.
Conclusions: After the survey, the dilemma still remains. At the Institute for Oncology and Radiology of Serbia, there is a total ban of smoking with one smoking area provided for patients. Smoking cessation courses will be organized at the Institute for patients undergoing cancer treatment and nicotine replacement therapy provided for disabled hospitalized patients not being able to quit.