and dosages were verified through the electronic records and patients' pharmacies.
A total of 143 elderly patients were included in the study. The mean age of the patients was 71 years old (range: 65−85). Patients took an average of 3.96 (min: 1, max: 14) prescription medications at home. Forty-five (31.5%) patients missed to mention at least one of their prescribed medications. Most patients correctly identified the prescribed indications for use (85.8%), prescribed doses (89.7%) and dosing frequencies (88.5%). However, few patients could name their medications (24.1%) and few were aware of precautionary instructions for use (11.8%). Survey on safe medication-use practices showed majority (70%) of patients could identify the medications they are allergic to. Almost half of patients would read drug labels (52.8%), discard medication when no longer needed (51.8%) and check expiry dates (43.3%). About a third would check with prescribers for changes in new prescription (30.5%). Only few patients would keep a medication list (16.9%).
A majority of our elderly cancer patients have good understanding of their prescribed medications. However, many of them do not keep a list of medications they are taking, and do not always read drug labels or check the expiry dates. Appropriate communication between healthcare providers and patients, patient education, use of aids such as medication diary and referral for medication review, could improve medication safety in this age group.

4014 POSTER

Safety and effectiveness of rehabilitation for elderly patients with hematological malignancies who received intensive chemotherapies

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Background: Physical function is frequently impaired in elderly patients with hematologic malignancies who receive intensive chemotherapy. This increases a risk of treatment-related mortality. However, optimal management of this problem remains to be established, while rehabilitation seems to be promising. The purpose of this study is to investigate the feasibility and effectiveness of rehabilitation for these patients.
Materials and Methods: Between December 2006 and February 2009, 22 elderly patients with hematologic malignancy who received induction chemotherapy or high dose chemotherapy followed by autologous stem cell transplantation received rehabilitation program supervised by exercise specialists in our institution. Rehabilitation program included walking, aerobic exercise, resistant exercise, and stretching. We retrospectively investigated safety, and effectiveness of rehabilitation using their medical records.
Results: Median age of included patients was 67 years old (range 60−81). Underlying diseases included acute myeloid leukemia (n = 14), acute promyelocytic leukemia (n = 2), acute lymphoblastic leukemia (n = 2), multiple myeloma (n = 2), and lymphoma (n = 1). Performance statuses of all patients on admission were 0−1. All patients received rehabilitation without complications. Rehabilitation program were performed in median 59% (range 17−94%) of planned rehabilitation day. The primary causes of discontinuance of rehabilitation were febrile neutropenia (n = 6), hemorrhage (n = 2), fatigue (n = 1), hypoxemia (n = 1), compression fracture (n = 1), and loss of patients' motivation (n = 4). Four patients died of treatment-related complications or disease progressions. The remaining 18 patients discharged on foot. Barthel index on discharge were similar to those on admission in 13 of these 18 patients. The strength of quadriceps femoris muscle in the remaining five patients was impaired. Four of them had a fall during admission.
Conclusions: The present study demonstrated the feasibility of rehabilitation during intensive chemotherapy for the elderly patients with hematologic malignancies. It also showed that rehabilitation might have contribute to maintaining physical function in these patients.

4015 POSTER

Early breast cancer in elderly women undergoing multidimensional geriatric assessment (MGA): does the consultation with Adjuvant!online change the choice of postoperative therapy?

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Background: Elderly breast cancer pts should be evaluated with an MGA to estimate the tumour-independent life expectancy, the risk of adverse events of endocrine (ET)/chemotherapy (CT) and to minimize their impact on daily life. Adjuvant!online (ADJ) program was built in order to provide oncologists with estimations of risks of relapse and death from cancer compared to survival or cancer-independent death at 5 and 10 years.
Materials and Methods: Clinical and comorbidity data of women aged $\geqslant$70 years were collected within a multicenter prospective observational study on adjuvant therapy for breast cancer. Estimations of potential benefits from adjuvant treatments and probability of non-cancer related death were calculated with the ADJ program and then presented to Monfardini, Crivellari and Molino to express an independent therapeutic choice blinded from full MGA data on which the actual choice of treating physicians (TRPH) had been expressed.
Results: 202 pts had undergone complete clinico-pathological assessment and full MGA to be considered eligible for this analysis. Median age was 77 years (range 70 to 92). Percentages of those left untreated were higher in the ADJB review (22%) compared to TRPH (9.5%, test K of Coen @0). Among 172 with estrogen-receptor positive disease, ADJB review and TPRH were not statistically different in prescription of adjuvant chemotherapy in adjunct to endocrine therapy (25% vs 13.7%) (K = 0.218 p = 0.000). In patients receiving chemotherapy, 2 ADJB reviewers tended to prescribe more frequently anthracyclines compared to TRPH (88% vs 50%, p = 0.539). Yet, prevalence of cardiac comorbidities among pts proposed for anthracyclines according to ADJB review was significantly high (75%).
Conclusions: Reviewing treatment choices by means of crude relapse estimations based on ADJB (tends to treat less the group at low risk and treat more aggressively the high risk group), probably because the perception of actual long term benefit of treatments is more objective. On the other hand, since ADJ considers the total comorbidity burden but not the system involved, decisions based on ADJ program without full MGA tend to neglect the high prevalence of cardiac contraindications to anthracyclines. ADJ should never substitute for full MGA in order to prevent specific organ-toxicities of CT.

4016 POSTER

Quality of life (QoL) in elderly patients (pts) with early-stage breast cancer treated with ibandronate (I) with or without capecitabine (X): results of the GBG 32 ICE trial

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Background: Although few studies are conducted in elderly breast cancer pts, they appear to benefit from polychemotherapy. However, in this population, the impact of treatment on QoL has not yet been reliably assessed. Therefore we included QoL assessment in the ICE study, which compared I alone versus I+X in elderly pts at increased risk of relapse.
Materials and Methods: Main inclusion criteria were: female $\geqslant$65 years with histologically confirmed breast cancer that is either node-positive or high-risk node-negative (tumour size $\geqslant$2 cm, grade > I, and/or ER- and PgR-negative); no prior chemotherapy; adequate organ function; and a Charlson score $\leqslant$2. Pts received either I alone for 2 years (50 mg p.o. daily or 6 mg i.v. every 4 weeks according to pt preference) or the same dose of I for 2 years + X 1000 mg/m^2 bid on days 1−14 q21 days for 6 cycles. Pts with ER/PgR-positive disease received endocrine therapy according to local/institution guidelines. The primary objective is to compare disease-free survival (DFS) with either I alone or I+X. Secondary endpoints include