C. Important psychological stressors were: Feeling of exhaustion and burn out in fathers (59.5%) and mothers (85.1%).
Results of t test showed psychological and Related to child stressors were statistically significant for mothers and fathers, but those of social stressors were not significant.
Conclusions: Results showed that parents will be severely stressful after diagnosis of leukemia in their children and this will be more sever when the child is in pain, receives chemotherapy injections, becomes hospitalized.
We think that nurses, physicians and other caregivers have to allocate more time to parents of leukemic children in order to recognize their current problems. Establishing societies are also essential for mental, psychological, and financial support.

4134 POSTER

Treatment of adolescents and young adults with T-cell acute lymphoblastic leukemia and lymphoblastic lymphoma according to the pediatric strategy for acute lymphoblastic leukemia – single center experience in Russia

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Background: The current treatment of T-cell lymphoblastic lymphoma (T-LBL) is based on the therapeutic strategy for acute lymphoblastic leukemia (ALL). Pediatric schedules based Berlin-Frankfurt-Munster protocol and adult Hyper-CVAD regimen with high doses of methotrexate are approaches that are mainly used. The purpose of this study was to compare the outcomes in adolescents and young adults (AYA) with T-LBL versus T-ALL treated by ALL-like regimen without high doses of methotrexate.
Materials and Methods: From May 1998 to July 2008, 17 (44%) patients (pts) with T-LBL and 23 (56%) pts with T-ALL (including 7 in the outcome of T-LBL) were enrolled. 7 pts with T-LBL have relapses after previously received from 1 to 7 (median – 4.5) schedules of B-NHL-like therapy. 16 (40%) pts were treated with the national protocols ALL-MB 91/2002 and 24 (60%) pts – ALL-BFM 90 or NHL-BFM 90 for non-B NHL. In ALL-MB 91/2002 protocols the pts receive four drug induction with dexametasone 6 mg/m^2 daily for 36 days, daunorubicin 45 mg/m^2 $\times$2, vincristine 2 mg weekly $\times$5 and and intrathecal (IT) cytarabine and IT methotrexate and IT prednisolone weekly $\times$5. Consolidation therapy included L-asparaginase in a constant dose of 10000 ME/m^2 weekly $\times$18 and 6-merkaptopurine 50 mg/m^2 (100%) daily and methotrexate 30 mg/m^2 (100%) weekly with weekly doses adjusted according to WBC count. Central nervous system (CNS) irradiation for T-LBL is performed only for pts with CNS involvement at diagnosis. Maintenance was carried out up to 24 months. The BFM protocol called for comparison as an effective standard therapy.
Results: Median age at time of presentation was 18.1 (range 15−42) years for T-LBL and 19.5 (15−36) years for T-ALL. All pts (100%) with T-LBL had advanced (III-IV) stages. The presenting sites of primary disease included mediastinal mass in 13 (81%) T-LBL vs. 12 (48%) T-ALL cases ($p = 0.034$). The bone marrow was involved (<25% blasts) in 5 (32%) pts with T-LBL. CNS involvements were found in 3 (19%) vs. 4 (16%) pts ($p > 0.05$) respectively. 15 (94%) pts with T-LBL are in complete response (CR) vs. 21 (88%) pts with T-ALL ($p > 0.05$). 6-years EFS was 75 vs. 67% ($p > 0.05$). 6-years OS was 81 and 79% ($p > 0.05$). The median follow-up was 4.5 years. The outcome did not depend from the treatment protocol.
Conclusion: The outcome of T-LBL and T-ALL is comparable for AYA. Previous failures of CHOP-like schedules haven't an absolute disadvantage prognosis for further ALL-like treatment.

4135 POSTER

The experience of seven Romanian pediatric oncologic centers in the medical care of acute myeloid leukemia patients

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Background: Children diagnosed with AML represent a small proportion of assisted oncologic pediatric patients.
Materials and Methods: Multicentric estimation of AML children diagnosed and treated at the Universitary Centers of Oradea, Craiova, Timisoara, Bucuresti, Targu Mures, Cluj and Constanta during the periods 1998–2002 and 2003–2007. Data about sex, age, date of diagnosis, FAB morphologic types, treatment protocols and outcomes were recorded.
Results: 43 children (67% boys and 32% girls) were diagnosed during the years 1998–2002: 2.3% were under 1 year age, 23% were 1−4 years old, 23% were 5−9 years old, 27% were 10−14 years old and 23% were 15−18 years old. In the following 5 years 39 children with AML were diagnosed (58% boys and 42% girls); distribution by age groups was 10.2% under 1 year, 25% of the age groups 1−4, 5−9 or 10−14, the rest of 12% of the age group 15−18. During the years 1998–2002 58% of children had FAB M0-M2 morphology, 23% FAB M3 morphology, 14% FAB M4-M5 morphology and 4, 6% had M6, M7 or undifferentiated morphology (other); during the years 2003–2007 the percent of children diagnosed with FAB M0-M2 and M3 morphology decreased to 41% and 13% and the percent of children diagnosed with M4-M5 and other morphology increased to 35.8% and 10.2%. The most used Protocol was BFM 93 (45 patients) followed by BFM 98 (21 patients); only 2 patients were treated with BFM 95 and 1 with BFM 90; others protocols were used in 4 patients and in 7 children the protocols were not mentioned or the children were not treated. Of 43 cases diagnosed in the first period, 20 deceased (46, 4% of cases) and of 39 patients diagnosed in the second period of time 22 deceased (56% of cases); 80% and 68% of deaths respectively were registered among the children with unfavorable FAB histology or among the untreated children.
Conclusions:
1. 82 children with AML were diagnosed in the last 10 years in 7 pediatric oncologic centers.
2. The higher number of deaths during 2003–2007 cannot be explained only by the differences in age groups distribution or by FAB subtypes.
3. Improvement of diagnosis, classification and of treatment modalities are needed for better results.
4. Finally, these data cannot be generalized for the whole country but emphasize the need of further multi-center collaborative prospective and retrospective studies as well as the need of diagnosis, treatment and supportive care optimization in order to improve our patients outcomes.

Nursing oncology

Oral presentations (Mon, 21 Sep, 11:00−12:30)
Telecare and lifestyle interventions

4150 ORAL

Is telephone follow-up by specialist nurses a cost effective approach?

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Background: This paper will report on the findings from an economic evaluation of traditional hospital follow-up versus telephone follow-up by specialist breast care nurses for patients treated for breast cancer in the United Kingdom (UK).
Materials and Methods: We conducted a cost minimisation analysis from a National Health Service (NHS) perspective using data from a randomised controlled trial that demonstrated equivalence between hospital and telephone follow-up in terms of psychological morbidity; 374 participants at low-moderate risk of recurrence were recruited to the study. The study was carried out at two hospitals in the North West of Engalnd. In a primary analysis we compared NHS resource use for routine follow-up (i.e. consultations, investigations and referrals) during a mean follow-up period of 24 months. Secondary analyses included patient and carer travel and productivity costs incurred and the NHS and personal social services costs of care in the minority of patients who developed a recurrence of their breast cancer.
Results: Participants in the telephone follow-up group had approximately 20% extra consultations (634 versus 524). Telephone consultations were of longer duration and conducted by senior nurses whereas hospital clinic