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POSTER

Factors associated with provider delay in the cohort ELIPSE 40 of young breast cancer women

A.D. Bouhnik¹, D. Rey¹, M.K. Bendiane¹, V. Buc¹, J.P. Moatti¹, P. Peretti-Watel¹. ¹Ors Paca – Inserm Umr912, Cancer, Marseille, France

Background: breast cancer incidence is quite low in young women and breast cancer is often diagnosed at more advanced stages than in older women. Delaying diagnosis and initiation of treatment is likely to result in worse prognosis. We attempted to identify factors associated with provider delay in a cohort of young women recently diagnosed with breast cancer.

Material and Methods: since July 2005, all consecutive women included in the Long Duration Disease File of the French National Health Insurance Fund for a diagnosis of primary non-metastatic breast cancer, aged 18–40 years and living in South Eastern France are asked to participate in a 5 years follow-up. Women who agree to participate answer a mailed self-questionnaire at enrolment (in the month after diagnosis) and then telephone interviews every year. Medical record is yearly collected from physicians. Between January 2005 and March 2009, 291 women have been included (response rate: 70%). Provider delay was defined as time elapsing between first presentation to a medical provider and cancer treatment initiation. This was studied in relation to socio-demographic factors, clinical variables and characteristics of the physician using logistic models.

Results: Provider delay was known for 282 women. Provider delay was 1 month or less for 38% of women, between 1 and 3 months for 46% and over 3 months for the last 16%. In multivariate analysis provider delay >1 month was associated with the women self detection of the cancer (OR = 12.5, 95%CI = [5–33]), with the diagnosis of non invasive breast cancer (9.1, [2.6–33]), and with the living place of the women (OR = 2.41 [1.3–4.6] for women living in towns <200,000 inhabitants, and OR = 0.68 [0.28–1.62] for women living in rural areas when compared with those living in towns ≥200,000 inhabitants). Socio-demographic characteristics of women, family history of breast or ovarian cancer, symptoms presentation, and specialty of first consulted physician were unrelated to provider delay.

Conclusion: Our study suggests that screen detected cancers and cancers detected in large towns or in rural areas are treated more quickly than self detected ones and those detected in medium size towns with dispersed medical services and care units. Educational programmes for physicians could help them to reduce diagnosis and treatment delay in the particular population of young breast cancer women.

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Patient satisfaction with nurse-led telephone follow-up after curative treatment for breast cancer: a randomised controlled trial

M.M.F. Bloebaum¹, M.L. Kimman¹, R. Houben¹, L.J. Boersma¹. ¹Maastricht University Medical Centre, Department of Radiation Oncology (MAASTRO), Maastricht, The Netherlands

Background and Aim: Due to the current debate on the cost-effectiveness of frequent out-patient visits in the follow-up (f-up) after curative treatment for breast cancer, alternative f-up strategies such as telephone and/or nurse-led f-up have been proposed. However, only limited data are available on the patient satisfaction with these alternative f-up strategies. Therefore, the aim of this study was to investigate patient satisfaction with nurse-led telephone f-up, compared to traditional outpatient clinic visits, using data from a randomised multicentre trial.

Materials and Methods: Between 2005 and 2008, 320 female breast cancer patients (stage I, II, III) were randomised into four f-up strategies, focussed on the first 18 months after treatment: 1) standard f-up; 2) nurse-led telephone f-up; 3) arm 1 with an educational group programme; 4) arm 2 with an educational group programme. Data on patient satisfaction were collected at baseline and 3, 6, and 12 months after treatment, using the validated, Dutch version of Ware's Patient Satisfaction Questionnaire III (PSQ-NL). The PSQIII consists of 43 items and 4 subscales. In addition to general satisfaction (PSQ total) it generates satisfaction scores for technical competence (TC), interpersonal aspects (IA), and access to care (AC). Scores range from 0 to 100. The results of arms 1 and 3 were compared with the results of arms 2 and 4, to compare standard f-up with telephone f-up.

Results: Data of 300 patients were analysed, 20 patients dropped out for various reasons. The overall patient satisfaction at 12 months was good: mean of 75.1 with a SD of 19.4, with similar values for standard f-up and telephone f-up: 74.9 vs 75.3 (p = 0.904). Furthermore, repeated measures analysis showed no significant differences between groups over time in any of the PSQIII subscales (PSQ total: p = 0.713, TC: p = 0.300, IA: p = 0.304, AC: p = 0.517) (power >0.80 and $\alpha = 0.05$).

Conclusions: No statistically significant differences in patient satisfaction were found between nurse-led telephone f-up and traditional outpatient clinic f-up. Hence, nurse-led telephone f-up might be an acceptable

alternative for hospital clinic visits. Besides reducing costs and burden on hospital clinics, it could be appropriate for patients with long travel distances or mobility problems.

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Efficacy of specialised nurses for newly diagnosed breast and gynaecological cancer patients: a quasi-experimental study

M. Eicher¹, B. Thürlimann², S. Aebi³. ¹Institute of Nursing Science/Universitätsklinik für Frauenheilkunde, University of Basel/Inselspital University Hospital, Basel/Bern, Switzerland; ²Senology Centre of Eastern Switzerland, Oncology, St. Gallen, Switzerland; ³Universitätsklinik für medizinische Onkologie, Inselspital University Hospital, Bern, Switzerland

Background: EUSOMA requires that breast cancer speciality units consist of a core team of specialists including specialised nurses. To date, research on the efficacy of specialised nurses in breast and gynaecological cancer remains inconclusive. The aim of our project was to test the efficacy of specialised nurses in these units on quality of life (QoL) and supportive care needs (SCN) of patients with breast and gynaecological cancer in the first three months after diagnosis.

Patients and Methods: We used a quasi-experimental design. From 210 eligible women we included a convenience sample of 113 newly diagnosed patients (53%, median age: 55.5, range: 35–85) from two specialist centres in Switzerland, one center served as intervention (N = 49), one as usual care group (N = 64). Most of the patients had an ECOG performance status between grade 0–1 and followed adjuvant treatment. The intervention referred to follow up by a multidisciplinary team including specialised nurses. The specialised nurses (non academic) provided regular counselling and support (shared consultations and individual counselling) according to a newly developed protocol. No specialised nurses were part of usual care. Baseline measurement occurred 2–4 weeks after definitive diagnosis. Follow up measurement occurred after 10 weeks. To rate their overall QoL, patients filled out a linear analogue self assessment scale ranging from 0–100 mm. They also completed the IBCSG QoL Core Form, which included seven similar scales focussing on QoL-related subdomains such as 'physical well-being', 'feeling of support', etc. SCN was measured with the 34-item SCNS. The 3-points scale measured perceived SCNs in five core domains, for which five averaged total scores were calculated.

Efficacy testing occurred using random-intercept regression analysis by examining whether the average evolution of QoL and the SCN measures differed over time for the two study groups, thereby controlling for confounding factors known to influence quality of life (e.g. different therapies, tumour stage, persons living in the same household).

Results: Baseline socio-demographic and medical data were similar between the groups. Evolution of QoL and SCN measures over time did not differ significantly between groups.

Conclusion: This study did not provide evidence on the efficacy of specialist care including specialised nurses for newly diagnosed patients with breast and gynaecological cancer. An improved model of nursing care is being developed, since the intervention seemed not being targeted enough.

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A new combined therapy strategy to breast cancer treatment: assay of E gene transfection associated to cytotoxic drugs in multicellular tumour spheroid

A.R. Rama¹, C. Melquizo², J. Prados², R. Ortiz¹, F. Rodriguez-Serrano², H. Boulaiz², J.A. Marchal², M. Perán³, I. Zafra¹, A. Aránega². ¹Institute of Biopathology and Regenerative Medicine (IBIMER), Human Anatomy and Embryology, Granada, Spain; ²University of Granada, Human Anatomy and Embryology, Granada, Spain; ³University of Jaén, Health Sciences, Jaén, Spain

Background: The low efficiency of conventional therapies in achieving long-term survival of breast cancer patients calls for development of novel options. The potential use of combined gene therapy is under intensive study. One approach uses the expression of genes encoding cytotoxic proteins that affect cellular viability. The E gene from \square X174 encodes for a membrane protein with a toxic domain which leads to a decrease in the rate of tumour cell growth. To improve the antitumour effect of the doxorubicin in breast cancer cell, we investigated a combined suicide gene therapy using this drug and E gene *in vitro*, using MCF-7 breast cancer multicellular tumour spheroids (MTS).

Materials and Methods: We cloned the gene E from \square X174 genome and tested the possibility of using it as an anticancer reagent in multicellular tumour spheroid of breast cancer (MTS). We investigated a suicide gene