4−10, median 7). Most pts presented with massive T recurrence (6 pts). Massive T and N recurrence in 2 pts. All the pts completed the treatment as scheduled. One case of G III skin toxicity inside the irradiated field occurred. Systemic skin rush occurred in 5 pts (G1 in four and G2 in one). No other relevant side effects occurred. At the end of the treatment, all pts showed a dramatic improvement in clinical conditions: complete control of pain without analgesics was achieved in 5 pts, while the remaining had VAS value between 1 and 2 with analgesics. CT scan demonstrated objective responses in three pts and SD in 2.
Conclusions: R-RT with C-mab and carboplatin results in clear improvement of clinical status and in some objective responses in this very heavily pretreated pts population. Toxicity was moderate and did not required treatment interruptions. This compassionate experience supports the development of clinical trials.

8580 POSTER

Social support service impact to the anxiety and depression of oral cavity cancer patients in Taiwan

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Purpose: To understand the impact of social support service to anxiety and depression of oral cavity cancer patients
Material and Methods: Oral cavity cancer patients who will receive radical surgery treatment are invited to take part in three arms randomized trial. Group A included basic social support program, group B included basic and previous treated cancer survivor volunteer visit and share, group C include frequent social worker visit except group B service. All patients are evaluated the anxiety and depression status by Hospital Anxiety and Depression Scale(HADS) and social support questionnaire included emotion, information, evaluation and solid support domains. Patients are evaluated at three time point: T1, pre-surgery; T2, 10−14 days after surgery (discharge from ICU) and T3, discharge from hospital.
Result: One hundred and thirty four oral cavity cancer patients are included in this study after informed consent. Median age is 47 and 98% are male. Seventy one percents of patients married. Most patients are blue-collar workers and have economic duty for the family. All patients receive radical surgery, 43% of them received adjuvant chemoradiotherapy and 24% received adjuvant radiotherapy. All patients are definite anxiety and depression at T1 (mean: 16.3), T2 (mean: 16.2) and T3 (13.8). The change is significant between T3 and others. Patients in C group have significantly better HADS improvement compared to group A and B but no difference between group A and B. There is no significant difference in social support domain among different patients group except patients feel more social support from family than medical personnel at T1 and patients with religion belief can appreciate more support from medical personnel.
Conclusion: All oral cavity cancer patients will have anxiety and depression condition from admission to discharge. Combined more intensive social support care can significantly improve patient anxiety and depression condition during admission. Further study is needed to know what change after discharge and long term condition.

8581 POSTER

Single centre experience in the use of induction TPF (docetaxel, cisplatin, 5FU) in locally advanced head and neck squamous cell carcinoma (LAHNC)

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Background: Induction TPF followed by radiotherapy (RT) or concurrent chemoradiotherapy (CTRT) has been shown to give improved overall survival compared to PF (cisplatin, 5FU) in LAHNC. This is a retrospective review of the experience of a single centre in the use of TPF in a non trial setting.
Materials and Methods: We reviewed 98 patients with stage 4 LAHNC treated between Mar 2006 and Feb 2009 with a modified version of the TPF regime used in TAX 324 (T and P 75 mg/m^2, both d1, F 750 mg/m^2/d, d2−5) q 3 wks. We aimed to deliver 3 cycles of TPF.
Results: Median age was 56 (35−74). 10 patients started treatment at a lower dose due to various co-morbidities. The first 7 patients did not receive antibiotic prophylaxis, 1 (14%) developed febrile neutropenia (FN). 49 patients received routine prophylaxis with ciprofloxacin 500 mg bd d5−15, of these 16 (33%) developed FN; 42 patients received both GCSF and ciprofloxacin routine prophylaxis, and 6 (14%) developed FN. 7 patients had minor cardiac events, 2 of which were associated with raised Trop T. There were 2 treatment related death during induction chemotherapy (CT). 16 patients had dose reduction due to toxicities. 93 patients proceeded to radical RT with concurrent cisplatin (56), carboplatin (17), capecitabine (2), cetuximab (7) or without concurrent CT (11). 1 patient received palliative RT. 1 patient underwent surgical management, 1 patient refused further treatment. Following induction CT, 94 patients were evaluable, 70 (74.5%) had PR, 9 (9.6%) had CR and 15 (16%) had SD.
Conclusion: TPF is deliverable in a non trial setting with manageable toxicities. Response rates were comparable to TAX 324 (84% versus 72%) with a higher proportion of patients proceeding to definitive RT or CTRT (96% versus 79%). Patients with both GCSF and antibiotic prophylaxis have lower risk of FN.

8582 POSTER

Radiosensitivity of neck metastases from squamous cell carcinoma of the head and neck assessed by immunocytochemical profiling of fine-needle aspiration biopsy cell specimens

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Background: To assess radiosensitivity of neck metastases of squamous cell carcinoma of the head and neck (SCCHN) by immunocytochemical profiling of fine-needle aspiration biopsy (FNAB) cell specimens.
Methods: Immunocytochemical reactions (localization, percentage and intensity of positive cells) to p53, cyclin D1, stefin A and Ki-67 was determined in FNAB cell samples of neck metastases from 21 patients treated with concomitant chemoradiotherapy with mitomycin C and cisplatin. Immunoreactivity was graded according to the percentage of positively stained cells (p53, cyclin D1, stefin A: <10% vs. $\geqslant$10%; Ki-67: <20% vs. $\geqslant$20%) and correlated to clinical characteristics and response to therapy.
Results: Six (28.6%), eight (38.1%) and 15 (71.4%) FNAB cell samples were classified as p53, cyclin D1 and stefin A positive, respectively. Ki-67 staining positivity ranged between 0−80% (median 10%). Threshold value of 20% classified nine (42.9%) FNAB samples as Ki-67 positive. Statistically significant predictors of favorable nodal response to chemoradiations were p53 ($P = 0.025$) and cyclin D1 ($P = 0.048$) negativity and Ki-67 positivity ($P = 0.045$). Neck mestastasis recurrence correlated only with Ki-67 immunoreactivity (no vs. yes: negative 4 vs. 8, positive 8 vs. 1, $P = 0.024$). Favorable profile of the tandem cyclin D1 and Ki-67 (one or both of the two) further improved the predicitive strength of these markers: it was associated with less advanced cN-stage ($P = 0.045$), complete nodal clearance after therapy ($P = 0.004$), absence of regional recurrence (0.006), and favorable survival status ($P = 0.045$). Its clinical repercussion was tested for two outcomes, i.e. regional response at 8−12 weeks post-therapy and regional disease reappearance: the the sensitivity, specificity and positive predictive value were 93.8%, 80%, 93.8% and 100%, 55.6%, 75%, respectively. Combination of all three markers (favorable immunocytochemical profile of $\geqslant$2 of them) did not add to their predictive value.
Conclusion: FNAB is non-invasive, simple and cheap procedure, which could serve simultaneously for diagnostic purposes and for radiosensitivity testing. Immunocytochemical determination of the tandem cyclin D1 and Ki-67 in FNAB cell samples from neck metastases of SCC of the head and neck seems to be valuable marker for predicting regional response to radiotherapy and might assist when deciding on appropriate primary therapy.

Central nervous system

Oral presentations (Tue, 22 Sep, 09:00−10:45) Central nervous system

8700 ORAL

Subclinical systemic disease and relapse pattern in primary central nervous system lymphoma (PCNSL)

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Background: An unresolved question is why some PCNSL spread systemically while most others do not. It was postulated that extracerebral relapse of PCNSL may represent a sequel of initial occult systemic disease rather than true extracerebral spread.