regimens. A planned analysis was performed based on tumor type. This analysis reports the most comprehensive data to date on the efficacy of an APR regimen in patients with cancers other than breast, and receiving predominantly non-AC-based MEC.

Materials and Methods: This phase III randomized, gender-stratified, double-blind trial enrolled patients with confirmed malignancies, naive to HEC or MEC agents, who were scheduled to receive at least one MEC agent. Patients received an APR-triple-therapy regimen (APR, ondansetron [OND], and dexamethasone [DEX]) or a control regimen (OND and DEX) administered orally. The primary efficacy endpoint was the proportion of patients with No Vomiting during 120 h post-chemotherapy. Treatment group comparisons were based on a logistic regression model with terms for treatment, region, and gender. Nominal p-values are reported.

Results: Among 832 patients in the modified-intent-to-treat population, 53% had breast cancer and 47% other cancer types (primarily colorectal, lung, or ovarian). Overall, more patients experienced No Vomiting in the APR group, regardless of whether they had breast cancer or another cancer type (differences of 16.6% and 10.8% vs. control, respectively, see table). Similar trends were seen in subsets of breast cancer patients receiving AC or non-AC chemotherapy, and in non-breast cancer patients receiving non-AC-based regimens. Overall, the incidences of adverse events were generally similar in the APR (61.9%) and control groups (66.5%).

Conclusions: The benefit of APR triple therapy has been shown to extend to non-breast cancer patients receiving non-AC based MEC, including those receiving oxaliplatin- and carboplatin-based therapy. In these patients, the APR regimen provided better efficacy over the control regimen in the prevention of CINV.

No vomiting in overall phase (0–120 h post-chemotherapy)	APR regimen % (n/m)	Control regimen % (n/m)	p-value
Breast cancer (all regimens)	69.3 (151/218)	52.7 (116/220)	0.0004
Breast cancer (AC)	67.7 (131/193)	51.3 (97/189)	0.0014
Breast cancer (non-AC)	80.0 (20/25)	65.2 (15/23)	0.21
Other cancers (all regimens)	83.4 (176/211)	72.6 (138/190)	0.006
Other cancers (carboplatin)	84.3 (86/102)	70.0 (63/90)	0.016
Other cancers (oxaliplatin)	81.9 (68/83)	74.6 (53/71)	0.32
Other cancers (any other chemo)	87.0 (20/23)	80.0 (20/25)	0.28

58LBA LATE BREAKING ABSTRACT

Prospective observational study of the proportion hospitalised cancer patients at risk of refeeding syndrome

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Background: Refeeding syndrome (RFS) has been recognised as a serious biochemical condition resulting from the sudden re-feeding of malnourished patients (Crook and Swaminathan 1996). Little exists in the oncologic literature about RFS (Marinella 2008). The aim of this study was to identify the proportion of cancer inpatients who were at risk from RFS.

Materials and Methods: In this study, RFS was defined as "A collection of electrolyte disturbances, including one or more of the following: hypophosphataemia (<0.7 mmol/l), hypokalaemia (<3.5 mmol/l), hypomagnesia (<0.5 mmol/l) occurring 2−4 days post dietetic intervention i.e. oral nutrition support, enteral or parenteral nutrition". A prospective observational study was undertaken over a 3 month period (March – May 2009). A total of approximately 1400 cancer patients hospital admission were screened for risk of malnutrition using a Trust screening tool based on validated McDougall et al 2008. High risk patients were reviewed by dietitians and blood results were obtained from patients' electronic records.

Results: Eleven percent (154/1400) of patients had a nutritional risk score >10 (high risk); 62% (95/154) were included in the study, 10% (16/154) of patients were excluded due to terminal stages of illness or death (unrelated to RFS) and data for 28% (43/154) patients was unobtainable. Thirty two percent (31/95) of patients were found to be at a high risk of developing RFS (NICE 2006) of which 45% (14/31) developed RFS. Amongst patients who developed RFS; 2 had refractory myeloma, 2 lymphoma, 3 head and neck cancer, 3 rectal cancer, 3 lung cancer and 1 prostate cancer. Mean weight was 57kg (SD 12.3), mean BMI 20 (SD 3.3) and mean weight loss over 3−6 months was 11.6% (SD 7.7).

Conclusions: This study found that RFS could occur in 45% of high-risk malnourished cancer patients. Recognition and appropriate management is mandatory in the treatment of this potentially fatal condition.