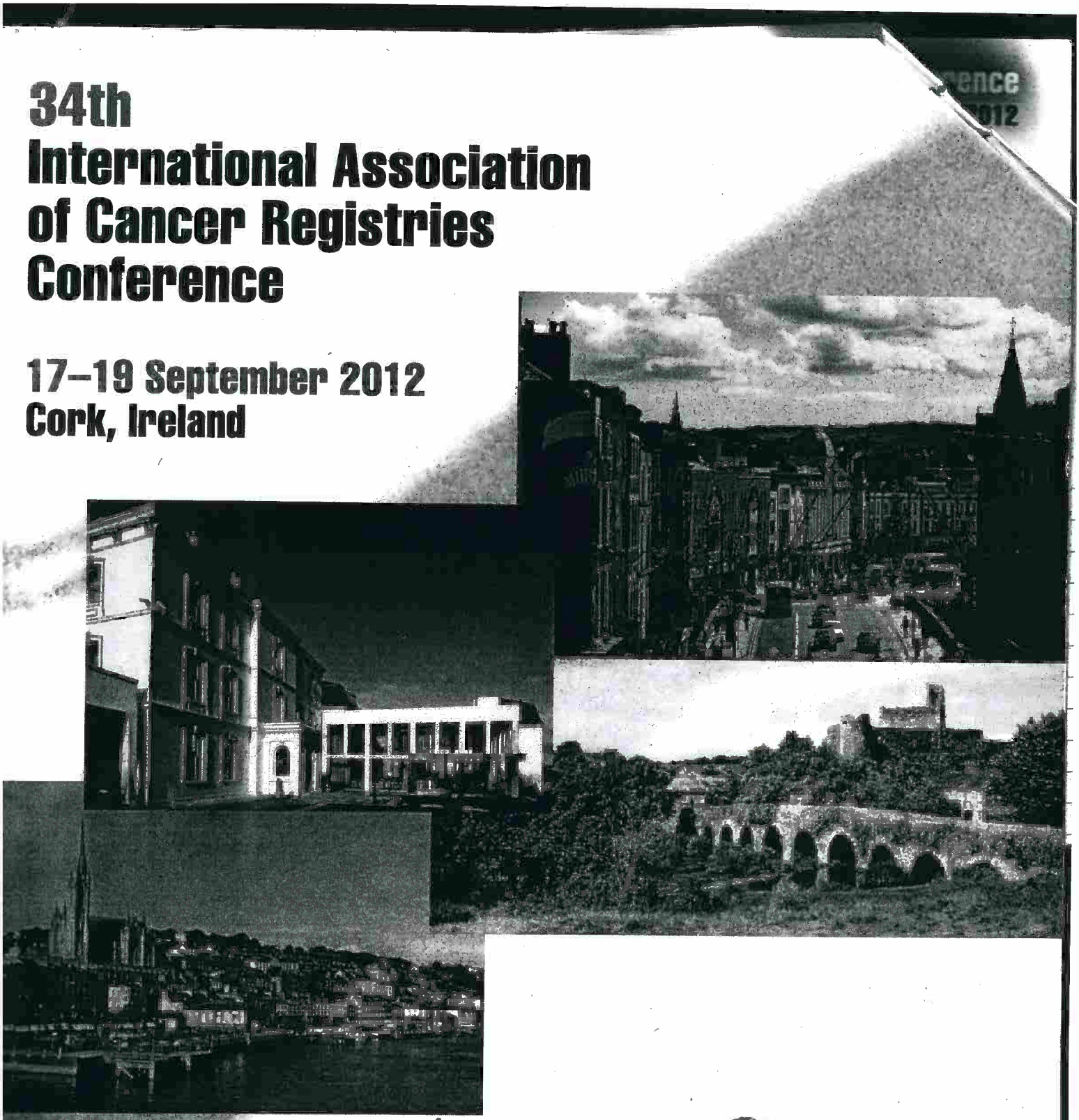
34th International Association of Cancer Registries Conference

17–19 September 2012
Cork, Ireland



IACR 2012

PROGRAMME & ABSTRACTS

Results

Comorbidity was present in more than two-thirds (n=5910) of patients. Thirty-day mortality rates ranged from 0.5% for rectal cancer patients <65 years to 12.8% for gastric cancer patients ≥75 years. Patients with comorbidity who underwent oesophageal tumour resection had the highest mortality rates, ranging from 8.4% for 30-day to 12.0% for 90-day mortality, while rectal cancer patients had the lowest rates, i.e. 4.3-6.4%, respectively. In multivariable analyses, cardiac disease (OR=1.74, 95% CI=1.32-2.30), vascular disease (OR=1.41, 95% CI=1.02-1.95) and previous malignancies (OR=1.38, 95% CI=1.02-1.86) in colon cancer, and cardiac disease (OR=1.81, 95% CI=1.10-2.98) and vascular disease (OR=1.95, 95% CI=1.11-3.42) in rectal cancer were associated with the highest 30-day mortality.

Conclusions

Postoperative mortality extends beyond 30 days. Comorbidity and older age are associated with early postoperative mortality after gastrointestinal cancer resection. Underlying comorbidity should be identified preoperatively with attention to patients' specific needs to optimally attenuate risk prior to surgery. A less aggressive treatment approach may well be considered in these groups.

QC3: Quality of Comprehensive Cancer Care in Southern Switzerland E14

Andrea Bordoni[1] Alessandra Spitale[1] Luca Mazzucchelli[2] Valentina Bianchi Galdi[1]

[1] Ticino Cancer Registry, Locarno, Switzerland
[2] Cantonal Institute of Pathology, Locarno, Switzerland

Background

Quality of Cancer Care (QoCC) studies have shown an improvement in oncologic care. QoCC can vary depending on the particular medical condition, with deficits in the adherence to recommended processes for basic care being frequently observed.

Methods

The QC3 is a prospective (01.01.2011-31.12.2013) population-based study, which analyses the QoCC of colorectal, prostate, ovarian, endometrial and lung tumours in Southern Switzerland. Patients >18 years, with incident tumours as listed above, treated both in the public and private hospitals and clinics, are enrolled. Together with dedicated working groups (WG), we identified a list of quality indicators (QI), then selected by a two-round modified Delphi process and validated by an international Advisory Board (AB).

Results

In 2011 we have defined the QI specific for all the above cited tumours. The initial colorectal cancer (CRC) IQ (n=149) underwent to the WG's revision and the selection (n=149) underwent Delphi process, which selected 89 QI, finally validated by the international AB (n=74). Here we present the preliminary results of the CRC incident in 2011 (n=252).

Conclusions

This study aims to produce evidence-based QI, whom application could allow an immediate change in the diagnostic-treatment process, that could be translated in a short-term benefit for patients.

Use of the hospital's cancer registry to evaluate breast cancer treatment in elderly patients E15

Marleen Van Roy[1] Jan Lamote[1,2] Tony Mets[3]

[1] Oncology Centre UZ Brussels
[2] Department of Senology and Oncologic Surgery UZ Brussels
[3] Geriatrics UZ Brussels

Background

Breast cancer patients (BCP) aged >60 are less likely to receive standard treatment. To evaluate parameters that might affect clinical care we linked the hospital cancer registry to the hospital medical database.

Methods

Retrospective analysis of newly diagnosed female BCP aged >60 (n=347) in the UZ Brussels between 2004 and 2007. Patients aged 60-69 were compared to patients â‰¥70. Diagnostic and treatment procedures, comorbidity and treatment waiting times were documented and their effect on therapeutic management was examined.

Results

Higher age was significantly related to less favourable stage at diagnosis. Age was unrelated to differences in diagnostic procedures or treatment waiting time. With increasing age patients were less likely to undergo breast conservative surgery, sentinel procedure, to receive chemotherapy or radiotherapy. There were no age related differences in axillary lymph node dissections. Comorbidity had a significant effect on receiving chemotherapy but not on radiotherapy. Patients over 80 were less treated according to surgery and radiotherapy guidelines.

Conclusions

Patients over 60 form a very heterogeneous group where age and comorbidity have an effect on treatment. The cancer registry forms a useful detection tool. Multidisciplinary assessment and individual discussion on implementation of guidelines is recommended for elderly cancer patients.