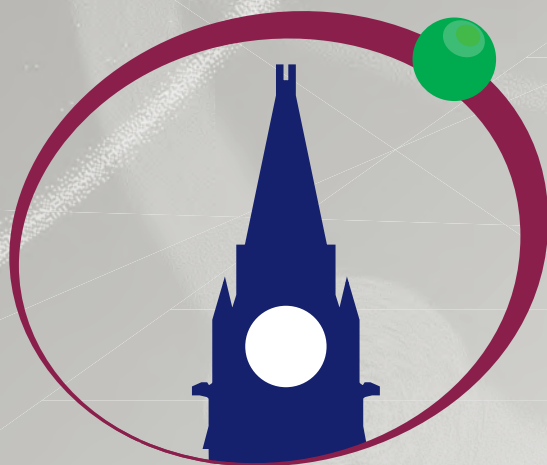


36th

INTERNATIONAL
ASSOCIATION OF
CANCER REGISTRIES
ANNUAL CONFERENCE

2014



ttawa

2014 IACR / NAACCR

P 1B.7

WHAT FACTORS AFFECT ACCESS TO SURGERY AND CHEMOTHERAPY FOR WELSH PATIENTS DIAGNOSED WITH LUNG CANCER?**Miss Rowena Bailey, Ms Rebecca Thomas, Dr Ceri White, Miss Julie Howe, Dr Dyfed Huws**

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Background

A local cancer non-governmental organisation enquired whether age was a factor in access to treatment for lung cancer in Wales. Our objective was to determine whether age and other factors were related to access to surgery or chemotherapy for lung cancer patients in Wales.

Methods

We identified patients diagnosed with lung cancer between 2008 and 2010 from the cancer registry, along with corresponding surgery and chemotherapy records. We modelled age, sex, performance status, deprivation and rurality using logistic regression to estimate the probability that a patient received either surgery or chemotherapy by the health board of residence in Wales.

Results

Surgery rates significantly decreased with increasing age; 24% received surgery in the 15–54 group compared with 6% in the 75+ group. Rurality had no significant effect on access to surgery. The adjusted rate of surgery was similar to the observed rate of surgery by health board of residence. Chemotherapy rates also decreased with increasing age; 56% received chemotherapy in the 15–54 group compared with 10% in the 75+ group. Access to chemotherapy was lower in: (i) deprived areas compared to affluent areas across all age bands with nearly a 13% absolute difference in the 65–74 group, (ii) rural areas compared with non-rural areas in all groups with nearly a 9% absolute difference in the 65–74 group. Age, performance status, deprivation and rurality were found to be significant in predicting whether lung cancer patients received chemotherapy. Performance status was the largest predictor for both treatments.

Conclusions

Access to surgery in Welsh lung cancer patients significantly decreases with increasing age, worsening performance status for males. Access to chemotherapy significantly decreases with increasing age, worsening performance status, increasing area deprivation in urban areas. Our findings have implications for health services, but further research is required to understand why these factors affect access.

P 1B.8

SWISS SURVIVAL STATISTICS: QUALITY OF LIFE STATUS FOLLOW-UP**PhD Matthias Lorez¹ Dr Andrea Bordoni² Dr Christine Bouchardy² Dr Silvia Dehler² Dr Silvia Ess² Dr Gernot Jundt² Dr Isabelle Konzelmann²**

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Background

While the assessment of case completeness is registration standard, completeness of registration of deaths is rarely reported. Even modest levels of unregistered deaths may lead to overestimation of survival when survival proportions are small, such as in old age, progressed disease stage and long-term survival. The present work addresses the completeness of ascertainment of deaths in Switzerland.

Methods

Included were primary malignant cancers diagnosed in 1999–2008, with follow-up (FU) in 2010, for stomach (C16), bowel (C18–20), liver (C22), pancreas (C25) and lung (C33–C34). Survival at 3, 5 or 10 years after diagnosis was estimated for patients age 80+ and for TNM class M1. The results were compared within Swiss registries, with the SEER data base and other European countries.

Results

Substantial efforts are taken to FU cancer patients in Switzerland. FU procedures 1999–2010 were found to be heterogeneous. All registries but one performed passive FU via annual linkage to the official vital statistics. In two registries, passive FU was incomplete because linkage has been attempted only if cancer was mentioned in the death certificate. In addition to passive FU, all registries but two performed active FU at least annually for all patients. In two registries, active FU was lacking for subsets of patients. Survival estimates from pooled data, for patients diagnosed with M1 or at age 80+, ranged within internationally published values, albeit toward the higher end. Comparisons among Swiss registries revealed a small number of unexpectedly high values.

Conclusions

Our approach to assess the quality of FU in patients indicating less than perfect procedures with the highest sensitivity, did not reveal improbable high survival estimates in pooled data. On the other hand, we were able to identify putative problems in single registries. Addressing these issues improves the reliability of our national survival statistics.