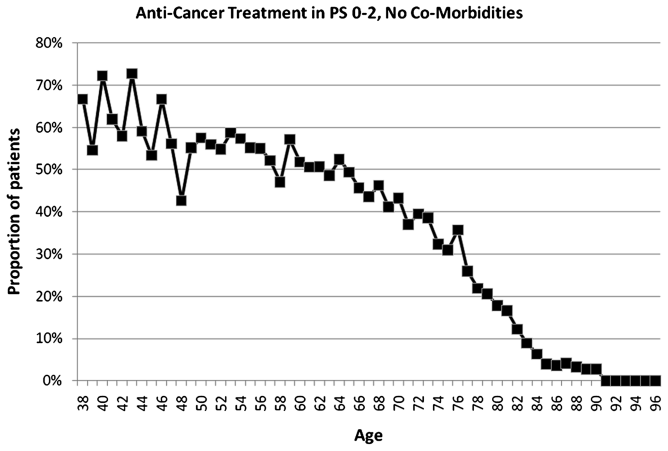
of predicted remains quite constant at around 70%. There is an increase in recording of co-morbidities from around 5% in young patients to around 20% in the very elderly. There is a clear and dramatic fall in a number of measures of process and treatment such as histological confirmation rate, anti-cancer treatment, and chemotherapy use beginning around the 7th decade of life. The histological confirmation rate falls from 75% at age 65 to 40% at age 85—the corresponding rates for specific anti-cancer therapy are 65% and 25%. More concerning is the finding that these variations persist when corrected for PS and co-morbidities (see Abstract P215 Figure 1), with treatment rates falling from 50% to 4%.



Abstract P215 Figure 1 Anti-Cancer treatment in PS 0—2, no co-morbidities

Conclusions Age appears to be an important factor in management decisions in English lung cancer practice. The results indicate that further work is warranted to determine how far the results can be explained by patient preference, appropriate physician judgement and physician prejudice.

P216 LUNG CANCER IN YOUNG PATIENTS: A RETROSPECTIVE STUDY

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Introduction Over-representation of women, more advanced disease staging at presentation, better performance status and similar survival figures have been noticed in younger (<50 years) lung cancer patients as compared to the general patient population with the disease.
Objective A retrospective study (December 2009) was done to derive clinicopathological data from young lung cancer patients treated in our hospital in the last 5 years. We also compared our findings with National Lung Cancer Audit (NLCA), 2007 in the UK. The NLCA data were considered as a reflector of the patients from all age groups.
Findings 28 patients were identified for the study. Median age was 48 years (37—50). 15(54%) were female. 75% had WHO performance status (PS)1 in patients with documented PS. 43% had family history of lung cancer. 89% were current smoker. Histology was achieved in 89%. 68% had non small cell carcinoma (NSCLC) including 39% adeno carcinoma, 24% had small cell carcinoma; 2 had carcinoid. 55% of histology proven NSCLC had stage 4 disease at presentation. 86% had some form of treatment (surgery, chemotherapy or radiotherapy). 5(18%) had resection. Survival related data are presented here:

	Median survival (days)	1 year survival rate (%)
All patients	254	32
Male	193	25
Female	261	36

Comparison between our findings and the NLCA data are presented below [Abstract P216 Table 1].

Abstract P216 Table 1

	NLCA data	Local data
Male:female	1.4:1	0.86:1
Histological confirmation	68%	89%
Stage IV at presentation in NSCLC	32%	55%
Active treatment received	51%	86%
Resection in NSCLC	14%	17%
Median NSCLC survival (day)	232	246

Conclusion Majority of these patients presented with advanced stage disease as in previously reported larger cohorts. Women were a majority but they had a better survival than men. 43% had positive family history suggesting a possible genetic factor. A good proportion in this patient group had favourable performance status resulting in higher resection rate and receiving of active treatment compared to overall patient population. However, this did not lead to better survival.

P217 WHAT'S HAPPENING TO LUNG CANCER IN FEMALES?

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Aim To examine trends in female lung cancer incidence.
Introduction Lung cancer incidence in men has been decreasing for the past 2—3 decades, while for females it has increased. Furthermore, to achieve the national cancer mortality target reduction, it is essential that lung cancer incidence reduces as this is a major contributor to the mortality target. Mortality trends closely mirror that of incidence due to the poor prognosis of lung cancer.
Methodology The UK Association of Cancer Registries dataset was used to identify female lung cancer cases diagnosed between 1985 and 2006 in England and its constituent Regions. Three year rolling directly age-standardised rates (standardised to the European population) was calculated. National deprivation quintiles were used, where deprivation was based on the income domain of Indices of Multiple Deprivation 2007. The postcode of residence of each patient was used to assign the relevant deprivation quintile.
Results England lung cancer incidence for females significantly increased ($p<0.01$) from 1985 to 1987 (32.3 per 100 000) and 2004—2006 (35.4 per 100 000). Incidence and trends across Regions varies significantly. Further analysis at Network/LA level shows even more extreme variation in trends. By 2030, it is anticipated that lung cancer incidence will be similar for both males and females in the South West Region. In the past 20 years the inequalities gap for females is widening. Incidence rates have increased in the most deprived population (30%) of the South West, while remaining relatively stable in the most affluent population of the region. Each Region shows different inequalities.