LUNG CANCER IN YOUNG PATIENTS: A RETROSPECTIVE STUDY

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Introduction Over-representation of women, more advanced disease 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. 45% 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:

<table>
<thead>
<tr>
<th></th>
<th>Median survival (days)</th>
<th>1 year survival rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>254</td>
<td>32</td>
</tr>
<tr>
<td>Male</td>
<td>193</td>
<td>25</td>
</tr>
<tr>
<td>Female</td>
<td>261</td>
<td>36</td>
</tr>
</tbody>
</table>

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.

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 contributor to the mortality target. Mortality trends closely mirror that of incidence due to the poor prognosis of lung cancer.

Results England lung cancer incidence 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.
Conclusion Smoking prevention is the key to reducing lung cancer. A lot of effort to encourage people to give up smoking has focused on men. Evidence of increasing female rates, more so in deprived areas, show that targeted efforts to support women need to be increased in order for large health gains to be achieved.

P218 IS THERE ANY VALUE IN OBTAINING A TISSUE DIAGNOSIS IN SUSPECTED LUNG CANCER PATIENTS WITH A PERFORMANCE STATUS 3-4?

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Introduction The National Lung Cancer Audit stipulates a minimum 75% tissue diagnosis rate in order to meet the standard required for Peer Review. Whilst this is imperative in patients suitable for potentially curative treatment (PS=1-2), in those with a poorer performance state (PS=3-4) it has been suggested that investigations aimed at obtaining a tissue diagnosis lengthen the diagnostic process without improving the patient journey, thereby wasting resource and diminishing the quality of care. To look at this further, we studied patients with PS=3-4 diagnosed at our large lung cancer unit (all-patients tissue diagnosis rate >80%), comparing their tissue diagnosis rate with treatment offered and ultimate outcome.

Methods All 108 patients (57 male) with PS=3-4 (18 PS=4) diagnosed at our unit during 2009 formed the study population (25% of total diagnoses). Eighty-eight diagnostic procedures were attempted in 72 patients (66%), and were successful in 59 of these (82%) (15 small cell, 40 non-small cell, 4 other malignancies).

Results Although a tissue diagnosis was more likely to be attempted in those with PS=3 than 4 (66/90 vs 6/18, $\chi^2=10.8$, p<0.01), it was no more likely to be successful (54/66 vs 5/6, $\chi^2=0.1$, p=NS). Those with a tissue diagnosis were more likely to be offered chemo or radiotherapy (active treatment) (28/59 vs 5/49, $\chi^2=17.5$, p<0.001), with the remaining patients benefiting from best supportive care (BSC). Furthermore, Kaplan–Meier plots (censored at 150 days) demonstrated that those who underwent active treatment had an improved clinical outcome (median survival: treated group 21 days [IQR 48–148] vs BSC group 16 days [6–56], p<0.001).

Conclusions This audit shows that patients with a poor performance state who undergo some form of active treatment gain a survival benefit. For clinical governance reasons, active treatment is unlikely to be offered to patients without a tissue diagnosis, underlining the need to appropriately investigate this patient group wherever possible. We achieved a tissue diagnosis rate of 55%, and exhort other lung cancer units to adopt a similar approach to improve the clinical journey of these unfortunate and sometimes under treated patients.

P220 HIGH PREVALENCE OF MALIGNANCY IN HIV INFECTED PATIENTS WITH ENLARGED MEDIASTINAL LYMPHADENOPATHY

doi:10.1136/thx.2010.151068.21

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Introduction Intrathoracic lymphadenopathy is commonly observed in patients infected with HIV. The broad range of aetiologies and the non-specific clinical picture constitute a diagnostic challenge which has not been previously addressed. Therefore we aimed to identify the causes of mediastinal lymphadenopathy in HIV infected patients presenting to our specialist unit and to characterise their mode of diagnosis.

Methods We conducted a retrospective analytical cohort study of HIV positive patients who underwent CT scanning of the chest between January 2004 and December 2008. Each patient was followed clinically for at least 12 months.

Results 234 consecutive patients underwent chest CT in the study period. Employing the conventional CT cut-off for significant lymphadenopathy of 10 mm in short-axis, mediastinal lymphadenopathy was present in 49 (21%) patients. In these 49 patients, the mean age was 40 (range 19–69) years. 43 patients were male and 24 of the male patients were homosexual. A specificity of 75 (91%) of patients were receiving antiretroviral therapy and 24 patients had a CD4 lymphocyte count below 250 cells x10^3/l. A specific diagnosis was made in 42 cases. Lymphoma was the most common diagnosis with 9 cases, followed by TB with seven cases. Six patients had reactive lymphadenopathy secondary to pneumonia. There were four cases of Castleman’s disease, four of malignancy and three of non-
P217 What's happening to lung cancer in females?

A Ives and J Verne

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