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P55 SHOULD INITIAL LUNG CANCER STAGING INCLUDE THE PELVIS?

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Introduction Current NICE guidance indicates that lung cancer should be staged by a contrast enhanced chest CT scan which includes the liver and adrenals, and to look for distant metastases those with potentially curable disease should be offered PET-CT scanning. However, the latter is expensive and limited in availability, and it has been suggested that including the pelvic area in the staging CT scan might obviate the need (Botchua *et al* 2012). We looked at 284 PET-CT scans performed for the staging of lung cancer in our unit to test this further.
Method We selected all PET-CT scans that showed distant metastases (and therefore upstaged the disease) for further scrutiny. In those where pelvic deposits were visible on the PET component, the CT element was reviewed to establish whether the diagnosis of pelvic metastases could have been made by CT scan alone.
Results 23 PET-CT scans (8.1%) identified distant metastatic disease, in 3 (1.1%) cases in the pelvic area. Of these, 2 had bony metastases that were visible on the CT element of the scan: in the remaining case the PET element demonstrated increased uptake around a joint replacement and CT component demonstrated a pathological fracture.
Conclusion This study has shown that if the pelvic area was included in the CT staging scan for lung cancer, in our cohort of 284 patients, only 3 (1.1%) would not have required a subsequent PET scan. In the remaining patients, the additional burden of pelvic CT in terms of radiation exposure and financial expense cannot be justified and therefore we do not recommend that the protocol for a staging CT scan in lung cancer is altered to include the pelvis.

P56 MALIGNANT PLEURAL MESOTHELIOMA IN NORTH EAST SCOTLAND

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Introduction We wished to highlight demographics and evaluate prognostic factors and outcomes in all patients regionally with confirmed malignant pleural mesothelioma (MPM).
Methods Data relating to all consecutive patients between 2002 and 2012 (inclusive) with biopsy proven MPM were identified from a local pathology database. Demographics, diagnostic method, histological sub-type, survival and laboratory parameters at diagnosis were extracted from computer archives. Comparisons were made between patients surviving greater than 1 year and less than one year.
Results 138 patients had confirmed MPM between 2002 and 2012 (118 (86%) male, 57% right sided, and median age 70 years (range 48–88)). Of these, 55% were classed as epithelioid, 16% biphasic, 16% sarcomatoid and 13% had no definitive typing. Overall median survival from diagnosis was 292 days (IQR 72, 497); 406, 297, 61 and 314 days for epithelioid, biphasic, sarcomatoid and "not defined" respectively. Factors associated with a higher risk of dying in less than one year after diagnosis were advanced age (median 73 vs 66 years, p = 0.0002), low haemoglobin (12.8 vs 14.0 g/L, p = 0.001), high platelets (366 vs 317 x10^9/L, p = 0.0269), low sodium (138 vs 139 mmol/L, p = 0.02), low albumin (38 vs 41 g/L, p = 0.0003), high alkaline phosphatase (101 vs 85 U/L, p = 0.013) and high C reactive protein (64 vs 26 mg/L, p = 0.0051). Between 2006–2012, 37 of 76 patients received chemotherapy; those who did had a greater median survival (median survival 423 days (IQR 326–624) vs 95 days (IQR 60–321), p = < 0.0001).
Conclusion Overall median survival in consecutive patients with MPM was 292 days, with adverse prognostic factors being low haemoglobin, sodium and albumin, high platelets, alkaline phosphatase and CRP and advanced age. Patients receiving chemotherapy had a better prognosis overall.

P57 FAST TRACK REFERRAL OF PATIENTS WITH MALIGNANT MESOTHELIOMA IS NOT ASSOCIATED WITH BETTER SURVIVAL

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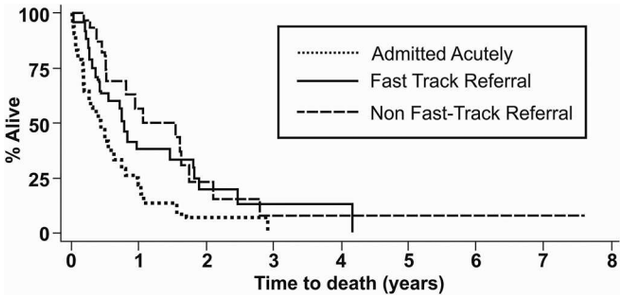
Background Few studies have examined the effect on survival in lung cancer of fast-track referral, while those that do have questioned the utility of the two-week fast track referral rule [1]. Paradoxically, delayed referral was associated with longer survival [2]. No studies which examined this factor in mesothelioma survival have been published. We therefore examined the effect of mode of referral on survival in malignant mesothelioma.
Methods All 88 patients with malignant mesothelioma in York and North Yorkshire between 2002–2011, where referral data was known, were examined for age at presentation, performance status (**PS**) and survival using Cancer Registry data with SPSS v19.
Results Three categories of referral were identified: 33 Fast Track (**FT**), 20 non Fast Track (**NFT**) and 35 Acute Admission (**AA**).

There was no difference in median [interquartile range] for age between **FT** (71.7 [68.3–74.6] years), **NFT** (69.4 [65.0–73.8 years) and **AA** (74.1 [70.7–77.5] years).

AA patients had a worse **PS** (2 [1.4–2.2]) than **FT** (1 [0.7–1.3]) and **NFT** (1 [0.5–1.5]), $p = 0.03$, analysis of variance (ANOVA). No difference was seen between **FT** and **NFT**.



Abstract P57 Figure 1.

Survival was significantly shorter in **AA** (3 [2.4–8.1] months) than for **FT** (6 [6.6–14.2] months) and **NFT** (10 [8.4–16.4] months), $p = 0.01$, ANOVA.

Results in the three groups are confirmed graphically using Kaplan-Meier survival analysis (**Fig.1**)

Conclusions We have shown that patients admitted acutely with malignant mesothelioma have a worse performance status and shorter survival than patients referred to clinic either via the **FT** two week rule or **NFT.** No survival benefit was seen for **FT**, perhaps because they were more advanced at presentation, as has been shown for patients with lung cancer.

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P58 THE CHARACTERISATION AND SUBJECTIVE ASSESSMENT OF COUGH IN LUNG CANCER AND MESOTHELIOMA: THE "CLAIM" STUDY

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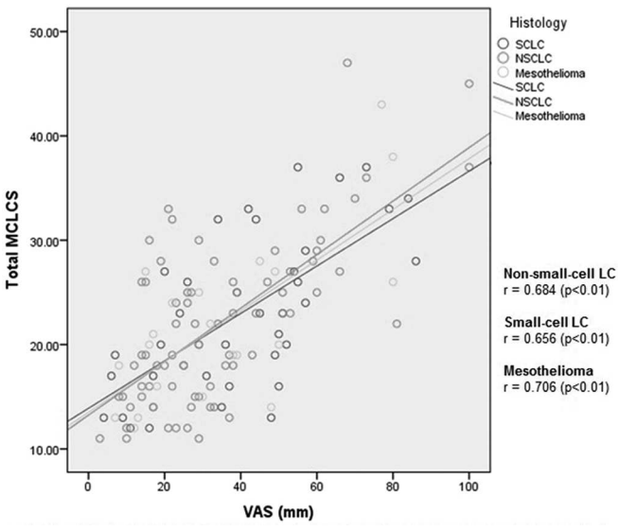
Introduction Lung cancer (LC) and mesothelioma (M) are usually terminal, with poor 5-year survival. Therefore, symptom control is crucial. Cough is a significant problem with physical, psychological and social consequences. It has a broad aetiology and its physiological mechanisms remain unclear. Methods for its assessment are unreliable and available treatments are limited; the absence of valid quantification of cough prevalence and impact hinders the development of novel therapies. CLAIM evaluates the impact and prevalence of cough in LC and M using validated assessment tools.

Methods Consecutive outpatients attending two cancer centres over a 5 week period completed the Manchester Cough in Lung Cancer Scale (MCLCS) and a cough severity visual analogue scale (VAS). Demographic and clinical data were collected.



Abstract P58 Figure 1. Correlation between VAS score and MCLCS score in lung cancer and mesothelioma.

Results Patients were of advanced age (LC mean 66years, M mean 71years), predominately male (LC 54.9%, M 75.0%), with advanced disease (advanced non-small-cell LC 80.5%, extensive small-cell LC 71.4%). Those on treatment largely received palliative treatment (LC 89.7%, M 100%). The majority of patients were performance status ≥2 (LC 51.7%, M 60%). Cough was reported by 58% of LC patients (n = 224) and 43% of M patients (n = 60); painful cough was reported by 23% and 18%, respectively. LC and M patients felt their cough warranted treatment in 53% and 40% of cases. Cough was associated with breathlessness (LC 61.9%, M 63.6%), disrupted sleep (LC 47.8%, M 52.4%) and interrupted conversations (LC 64.6%, M 59.1%). There were moderate-strong correlations between MCLCS and VAS scores in all patient groups [non-small-cell (r = 0.68), small-cell LC (r = 0.66) and mesothelioma (r = 0.71), all p < 0.01].

Conclusions This is the first study comparing the prevalence and impact of cough in LC and M using validated cough-specific assessment tools, in a clinically representative population. Cough is common in these cancers and has marked effects on quality of life. In the absence of evidence-based treatments, it represents an unmet clinical need. The high prevalence of cough in M is counterintuitive, in view of the tumour location. The MCLCS and VAS correlations suggest these are complementary tools which perform reliably in these disease groups.

P59 THE CHARACTERISATION OF COUGH IN LUNG CANCER

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10.1136/thoraxjnl-2013-204457.209

Introduction Cough in lung cancer (LC) is a distressing symptom with a significant impact on quality of life (QoL), and no effective therapies. Little data is available defining the proportion of LC patients affected by cough or its impact. This study determines the prevalence and characteristics of cough in LC using validated assessment tools, including the new LC-specific impact scale: Manchester Cough in Lung Cancer Scale (MCLCS).

Patients and methods Consecutive patients attending a single-centre LC outpatient oncology clinic were enrolled over a 5-week period. Every patient was asked "do you have a cough?" Patients who answered yes had their cough assessed using a cough severity Visual Analogue Scale (VAS) and the MCLCS. Clinical and demographic data were collected.

Result A total of 224 patients were enrolled; 55% male; 10% never smoked; 31% small cell lung cancer (SCLC) and 52% had a performance status (PS) of 2–3. The cough prevalence was 58%; 53% felt their cough warranted treatment and 23% reported painful cough. Mean MCLCS 22.7 (8.1 ± SD, range 0–50: 50 = worst cough QoL) and VAS scores were 36mm (21.3 ± SD). Painful coughs scored higher on the VAS and MCLCS (mean VAS 45.7mm vs.33.3, p = 0.034, mean MCLCS 28.0 vs. 19.6 p≤0.005). Coughs warranting treatment also scored higher on the VAS and MCLCS (mean VAS 47.2 vs. 23.8 p≤0.005, mean MCLCS 25.4 vs. 17.1, p≤0.005 respectively). Cough prevalence was higher in patients off anti-cancer therapy (63% vs. 50%, p = 0.048). Cough had a greater impact on mean MCLCS scores in poor PS patients (p ≤0.0005).

Conclusion This is the first study to assess the prevalence of cough in a large clinical cohort of outpatients with LC and to characterise cough using validated assessment tools. Cough was most severe coughs and had greatest impact on quality of life in