

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.

REFERENCES

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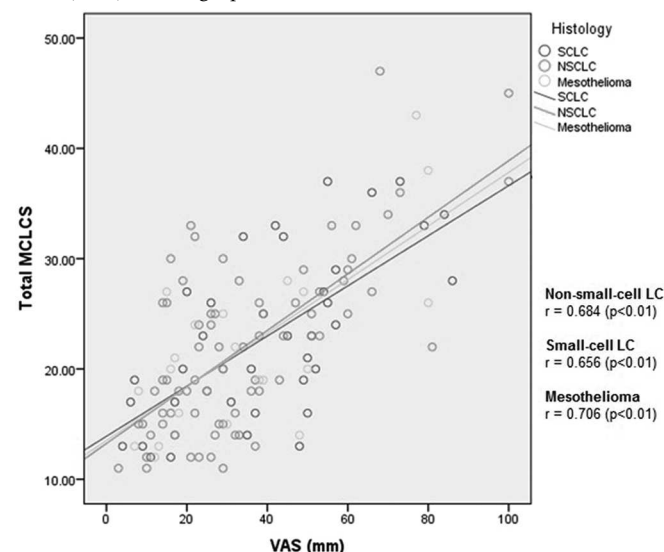
P58 THE CHARACTERISATION AND SUBJECTIVE ASSESSMENT OF COUGH IN LUNG CANCER AND MESOTHELIOMA: THE "CLAIM" STUDY

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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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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 ($8.1 \pm$ SD, range 0–50: 50 = worst cough QoL) and VAS scores were 36mm ($21.3 \pm$ 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 $p \leq 0.005$). Coughs warranting treatment also scored higher on the VAS and MCLCS (mean VAS 47.2 vs. 23.8 $p \leq 0.005$, mean MCLCS 25.4 vs. 17.1, $p \leq 0.005$ 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 ($p \leq 0.0005$).

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