radical treatment between August 2011 and August 2012. Electronic records were reviewed and baseline parameters, including blood results were recorded. mGPS (based on CRP and Albumin), NLR and PLR were calculated. All cases were subject to multidisciplinary assessment, detailed staging and 2-year follow-up. Kaplan-Meier plots were generated for mGPS, NLR, PLR and compared using log-rank for trend and log rank. Differences in mortality were quantified using Hazard Ratios (HR). Differences in stage proportion were compared using the Chi-Square z test.

Results 97 patients were identified. 44/97 (45%) were male, mean age 70 (± 8) years. 54/97 (56%) underwent surgery, 43/97 (44%) underwent radical RT. NLR and PLR provided no useful prognostic information. In surgical patients only, increasing mGPS was associated with decreasing 2-year survival (see Figure 1(a)), with curve separation occurring 1 year post-resection. Pre-operative mGPS 1 and 2 were associated with HR for death of 3.9 (95% CI 0.8–39.5, p = 0.095) and 5.8 (95% CI 1.38–106, p = 0.02) relative to mGPS 0. There were less Stage I and more Stage II patients in the mGPS 1 group (see Figure 1(b)), mGPS 0 and 2 appeared well matched for stage.

Conclusion These data suggest that pre-operative mGPS may be useful in risk-stratifying patients with early stage NSCLC. The late survival curve separation observed suggests recurrent malignancy rather than post-operative complications are likely to explain this. If confirmed prospectively, integration of mGPS into staging algorithms might allow more effective targeting of adjuvant therapies.

P76 WHEN IS IT SAFE TO DISCHARGE RESECTED STAGE 1A/1B NSCLC FROM THE CLINIC?

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Introduction We have previously shown that the majority of recurrent disease occurs within the 2 years of lung cancer resection.[1] Follow-up protocols vary between centres but often involve serial CXR examinations. At Salford we also perform a CT scan at one year after surgery. Given that the prognosis for early stage lung cancer is good, the question arises as to when it's safe to discharge such patients from follow-up? Traditionally this has been set at 5 years.

The Salford Lung Cancer d-base provides comprehensive data on all patients in Salford undergoing surgical resection including outcomes during follow-up. To date, 255 patients have undergone resection of non-small cell lung cancer and the rate of resection is increasing year on year.[2] This audit sets out to review the data following introduction of routine PET scans to our service in 2005 with a view to providing guidance as to when it might be safe to discontinue regular follow-up of early stage disease.

Abstract P76 Table 1 Patterns of survival for patients with 1A or 1B disease

Stage	0yr	1 yr	2 yr	3 yr	4y
1A	23	23	22	22	22 (96%)
1B	20	18	17	17	17 (85%)
1A + 1B	43	41	39	39	39 (91%)

Methods All patients undergoing surgical resection were first identified from March 2006 to July 2010. Those with a post-operative stage 1A or 1B disease were then extracted; allowing a 4 year follow up for each patient. Those patients dying within 4 years of surgery from non-cancer and non-lung cancer causes were excluded to produce a selected cohort of patients. 1, 2, 3 and 4 years survival figures were then produced for each category of disease (1A, 1B and 1A+1B) to observe for any serial changes.

Results A total of 89 patients underwent surgical resection during the study period of which 55 (62%) were 1A or 1B disease. After exclusions, 43 patients (23 × 1A and 20 × 1B) were available for analysis. As expected, relapse rates were low and occurred in the first 2 years. Survival rates were high but remained stable after 2 years of follow up (see Table). The use of 1 year CT scans detected just 2 relapses.

Conclusions Allowing for the small numbers, the above audit supports a move away from traditional follow-up protocols to discharge alive and well patients with resected early stage disease from the clinic at 2 years. The role of imaging surveillance during the first 2 years requires further exploration.

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P77 CARCINOMA IN-SITU AT THE BRONCHIAL RESECTION MARGIN – A CASE FOR ROUTINE SURVEILLANCE WITH AUTOFLUORESCENCE BRONCHOSCOPY

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Introduction Lung cancer is the leading cause of cancer mortality worldwide, with squamous cell carcinomas commonly arising in the central airways and accounting for nearly 30% of cases. Progression from normal bronchial epithelium to carcinoma in-situ (CIS) has been well described, and is found at the resection margin after lobectomy in up to 2.5% of cases; however, its fate has not been defined.

Method Cases referred to the autofluoresence bronchoscopy (AFB) surveillance programme at this institution were analysed retrospectively from 1999–2012, for all those shown to have CIS at the resection margin following surgery for TxN0M0 squamous cell carcinoma. Patients underwent longitudinal assessment of the tracheobronchial tree to (a) confirm CIS at the resection margin and track its fate over time (b) characterise development of other preinvasive lesions.

Results Twenty-two cases were identified with a median interval of 6 months (range 3–9) from surgical resection to first AFB. Thirteen patients (59%) were confirmed to have CIS on biopsy at the bronchial resection margin during the first AFB. Eleven (85%) of these progressed to invasion over a median interval of 37 months (range 4–85). A subgroup of these (5 patients) developed 8 invasive cancers at sites distant to the anastomotic site and 9 patients had >1 CIS lesion at a distant site. Two patients (9%) found to have CIS after initial post-resection AFB, persisted after follow-up of 36–45months. Although no progression