(>80 age years) undergo this treatment often because of their perceived frailty and complication rates. Since lung cancer is a disease of the elderly, with up to 30% occurring in this age group, we were interested to review the results of attempted curative resection in older patients referred to our tertiary thoracic surgical unit.

Methods We reviewed the medical records of all 1481 patients aged 60 or older who had undergone single or bi-lobectomy with curative intent from 2001 to 2008, and divided them into age groups 60–79 (1360 cases, 663 female) and 80+ (121, 41). We looked at their clinical parameters, and then compared the results of surgery in terms of short-term mortality, complication rates, and length of stay.

Results The older patients had smoked less (median 30 pack years [IQR 20–50] vs 40 [20–54], $p<0.5$), and had better lung function (FEV₁ 88% [73–103] vs 81% [66–93], $p<0.001$), but had more heart disease (41% vs 29%, $p<0.001$). Postoperative results are given in the Abstract P192 table 1.

Abstract P192 Table 1

Outcome	Under 80 (n=1360)	80 or over (n=121)	p Value
Respiratory complication	292 (22%)	39 (32%)	0.01
Cardiac complication	165 (13%)	26 (22%)	0.004
Wound complication	20 (2%)	4 (3%)	0.13
ITU readmission	90 (7%)	16 (13%)	0.01
Return to theatre	103 (8%)	12 (10%)	0.36
Post-op length of stay	8 (6–10)	10 (7–13)	<0.0001
In-hospital mortality	27 (2%)	7 (6%)	0.02

Conclusion Although the older patients had more postoperative complications, 94% survived the procedure, indicating that surgical resection with curative intent is a viable proposition in selected cases of lung cancer in the elderly. Thus, age should not be a bar to surgical treatment in the older age group, and this study reiterates the need to consider potentially curative surgery for all age groups with this life threatening disease.

P193 ASSESSMENT OF PERFORMANCE STATUS IN LUNG CANCER: DO ONCOLOGISTS AND RESPIRATORY PHYSICIANS AGREE?

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Introduction and Objectives Performance status assessment in lung cancer patients is essential to assess prognosis and plan management. Inter observer variability has been documented between oncologists, their patients and other professionals (Blagden *et al* 2003). No study has previously examined whether this variability also exists between respiratory physicians and oncologists. We hypothesised that performance status assessment would vary between respiratory physicians and oncologists. We also questioned whether frequency of outpatient contact with lung cancer patients or stage of training affected assessment.

Methods 8 case vignettes were sent to respiratory physicians, oncologists and speciality trainees using an online survey tool. The speciality, seniority and frequency of outpatient contact were recorded. The Eastern Co-operative Oncology Group Score (ECOG) was used due to greater familiarity and increased inter-observer reliability in previous studies.

Results 119 respondents completed the survey—62% were oncologists. 85% of respondents were consultants and 62% reviewed patients frequently (weekly) in outpatients. 20% saw lung cancer patients rarely or never. Individual assessments were broad, with seven case vignettes receiving 3 or more performance status (PS) ratings. 6 cases crossed the therapeutic boundary between PS 2 and PS 3. In one case assessment ranged from PS 0 to PS 4. However,

Krippendorfs α assessment (K α) (Hayes and Krippendorf, 2007) showed overall agreement at 0.59. This confirmed wide individual variation but closer group agreement. There was no difference in assessment between oncologists and respiratory physicians—K α 0.61 and 0.63 respectively. Equal K α values of 0.62 between Speciality trainees and Consultants showed stage of training had no impact. Frequency of review did not affect level of agreement with K α values of 0.62 and 0.64 for frequent reviewers vs non-frequent.

Conclusions Rating of performance status varies widely between individuals. This may negatively affect patients if only individual assessment is performed. However, respiratory physicians and oncologists exhibit statistically significant agreement in their assessments. This is not affected by stage of training or frequency of outpatient contact. This study highlights that review of performance status across specialities or by multiple assessors (The MDT) is likely to lead to more consistent assessment.

P194 WHY DO LUNG CANCER PATIENTS STILL DIE IN HOSPITAL?

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Aims The Department of Health proposes “to offer all adult patients, regardless of their diagnosis ... access to high quality palliative care so that they can choose ... to die at home.” We, therefore, studied those with lung cancer patients who died in our institution during 2010.

Results 41 patients (33% of our annual notifications) died in hospital; 26 case records were retrieved complete (all had previously been diagnosed with lung cancer); mean age 70.6 years (53–85). 25 lived in their own dwelling (5 alone; 2 of these with only social care support) and 1 in a nursing home. 5 had been in receipt of radical treatments; 21 were in receipt of palliative interventions and the nursing home resident had no active treatment. Mean time from diagnosis to final admission was 296 (188 for those without radical treatments) days. 13 patients admitted via GP; six through A&E seven from Oncology or Palliative Care outpatients. 12 had acute medical problems (eg, pneumonia, CCF); one had intestinal obstruction; 11 had progressive disease-related symptoms (eg, progressive brain metastases); two had social issues precipitating admission. No clear documentation of preferred place of death was identified at admission; during this final admission 14 indicated their preferred place of death—10 for home; four were too unwell for discharge; one had unaddressed social issues; three families couldn't cope and two were re-admitted by their GP within 24 h of discharge. All patients were in receipt of specialist palliative care during the admission and 15 died on the Liverpool Care Pathway.

Conclusion 50% of these lung cancer patients (representing 16% of our annual cases) were admitted with acute medical problems. Those identified as wishing to die at home were unable to be discharged. To prevent the remaining 50% of this population being admitted to hospital will require a significant change in practice by both primary and secondary care teams and an investment in community palliative care services. In-hospital palliative care is of a very high standard.

P195 OUTCOMES IN EMERGENCY ADMISSIONS WITH LUNG CANCER: A 1-YEAR PERSPECTIVE FROM A TEACHING HOSPITAL

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Introduction Nationally it is known that 23% of all cancers present as emergencies.¹ Baseline data for all cancer-related admissions for 2008/

Abstract P195 Figure 1

2009 in the Trust demonstrated that patients with lung cancer had both the highest rate of unscheduled admissions and the greatest number of inpatient bed days compared with other cancer sites. In 2010, there were 220 new cases of lung cancer diagnosed across the Trust. We reviewed the records of all patients admitted to the Trust with a coded diagnosis of lung cancer retrospectively. This did not include those patients seen in A&E and discharged. Cases were recorded as known (diagnosed prior to that admission and known to the service), or new (diagnosed on or as a result of that admission).

Results In 2010 there were 110 admissions overall with lung cancer. 34 patients (16.4%) had their lung cancer diagnosed as a consequence of that admission. 26/34 (76%) presented on the general medical take; the remainder to Care of the Elderly team as they were ≥ 80 . At diagnosis, the majority were ECOG performance status 3/4, thereby precluding any active cancer treatment. 29 patients (85%) were diagnosed with metastatic disease at presentation. One quarter of those diagnosed on that admission died, with a median survival of 8 days. The mortality at 30 days was 50%; 23/34 (68%) had died within 6 months of the admission. Only two patients (6%) survived 1 year. Access to specialist palliative care and palliative treatments such as radiotherapy/chemotherapy/stent insertion was good.

Conclusions Patients diagnosed on an acute admission with lung cancer generally present with advanced disease and poor performance status. Treatment options are limited and the overall survival is very poor. This leaves little time for patients and their families to come to terms with their condition and affects where patients may die. This data has been used to inform local awareness projects in both the primary and secondary care community. As a result, a novel rapid access clinic has been established for newly presenting patients to enable swift diagnosis and where possible an alternative to admission.

REFERENCE

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P196 THE COST EFFECTIVENESS OF PET SCANS IN THE RADICAL TREATMENT OF LUNG CANCER PATIENTS IN A DISTRICT GENERAL HOSPITAL

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Introduction and Objectives This retrospective study compares the cost of PET scans with the cost of surgical intervention; for patients with lung cancer suitable for radical therapy.

Methods The number of patients referred for PET scans by our lung Multidisciplinary Team (MDT) in 2010 was identified from our lung cancer database. All patients' management plans were reviewed via our electronic lung cancer database (Somerset Cancer Registry), and copies of MDT and clinic letters. The cost of PET scans, lobectomy and mediastinoscopy were provided by our thoracic surgery tertiary centre, the Bristol Royal Infirmary, as follows; PET scan £850, uncomplicated lobectomy £6000, uncomplicated mediastinoscopy £2000.

Results In 2010 the lung MDT referred 84 patients for PET scans (see Abstract P196 table 1). 52 scans were requested with the intention of referring patients for radical treatment. Of these 52 scans, 22 patients had their lung cancer upstaged following PET scan (three increased tumour staging, nine increased nodal staging, and 10 identified distal metastases). 26 patients had unchanged staging on PET scan compared with CT scan. Four patients required further imaging. The total cost of PET scans was $52 \times £850 = £44\,200$. As a result of upstaging on PET scan, 22 patients were not referred for radical surgery (lobectomy) with the potential cost saving of $22 \times £6000 = £132\,000$. Furthermore, in view of PET scan activity identified in mediastinal nodes, nine patients were not referred for mediastinoscopy with the potential cost saving of $9 \times £2000 = £18\,000$. Therefore the total potential cost saving after accounting for PET scan expenditure was £105 800.

Abstract P196 Table 1 Reason for PET scan request

Reason for PET scan request	Number of patients (total n = 84)
Suitable for radical therapy	52
Pulmonary nodule assessment	26
Restaging after oncological therapy	4
Metastasis from extrathoracic malignancy	2

Conclusions The study demonstrates the cost effectiveness of PET scanning in the radical treatment of lung cancer patients in a district general hospital. Limitations of the study include an under-estimation of the cost of surgery as some patients will develop post-operative complications. Furthermore, the study has not included the cost of palliative treatments provided to patients who were not referred for radical treatment after PET scan. The study did not assess the concurrent advantages of reduction in morbidity and mortality for patients avoiding unnecessary surgical intervention.

P197 PET-FDG STAGING FOR LUNG CANCER: OUTCOME OF HIGH UPTAKE FDG AT EXTRATHORACIC SITES

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Background Positron Emission Tomography (PET) scanning with F-18 2-fluoro-2-deoxy-D-Glucose (FDG) is pivotal in staging lung carcinoma where curative intent is proposed and increasingly is being evaluated in measuring response to therapy as well as in detecting recurrent disease. Staging nodal disease in the mediastinum apart, PET has also been reported to improve the non-invasive detection of unsuspected extra thoracic disease in upto 10% and may alter management in up to 40% of cases [McLoud TC, Cancer Imaging 2003]. The limited resolution of PET, however,