non-adherence in 23/63 (36.5%) and good adherence in 29/63 (46%). Agreement between clinician assessment and prescription issue data were seen in only 23/63 (36.5%) of cases and overall agreement using a weighted κ coefficient was poor (weighted agreement 63.5%, expected agreement 58.8%, κ = 0.11, SE 0.1, z=1.16, p=0.12). There was no relationship between patients’ age, gender, Juniper asthma control score, prescribed inhaled corticosteroid dose or FEV1 percent predicted and the chances of agreement or disagreement between the two methods.

Conclusions Clinical judgement alone appears to be a poor predictor of adherence to medication in patients with difficult asthma. The assessment of non-adherence requires objective measurements. Prescription issue data are one such measurement; but further work is required.

Lung cancer: advances in treatment

**S85** BRITISH THORACIC ONCOLOGY GROUP TRIAL, BT02: RANDOMISED PHASE III CLINICAL TRIAL OF GEMCITABINE COMBINED WITH CISPLATIN 50 MG/M2 (GC50) VS CISPLATIN 80 MG/M2 (GC80) VS CARBOPLATIN AUC 6 (GCb6) IN ADVANCED NSCLC

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Background The standard of care for advanced NSCLC is platinum-based chemotherapy but the optimal dose of cisplatin and comparison with carboplatin is uncertain. With median survival at 8–12 months, the impact of such treatment choices on patients’ quality of life (QoL) is important. The BT02 trial is a large phase III randomised trial comparing three treatment arms: gemcitabine (1250 mg/m2 day 1 and day 8) with either cisplatin 80 mg/m2 (GC80), cisplatin 50 mg/m2 (GC50) or carboplatin AUC6 (GCb6). The trial was innovative in aiming to collect QoL data on all trial patients and is the largest study to date addressing this issue in NSCLC.

Methods OQoL was measured at each cycle of chemotherapy and each follow-up visit using standard, validated questionnaires: EORTC QLC-C30, LC13 and EQ-5D.

Results More than 8000 questionnaires were returned from 1363 randomised patients with compliance around 90% during the treatment period. At pre-randomisation, the mean global heath status score and EQ-5D utility score were 62% and 0.66. On initiation of treatment, patients in all three treatment arms had improved pain, cough, haemoptysis, insomnia, appetite loss and emotional functioning with associated improvements in global measures of QoL but these benefits generally fell away after completion of chemotherapy (12+ weeks). GC50 performed better in terms of the functioning scores and in terms of fatigue, nausea and vomiting while GCb6 performed worst for dyspnea. All treatments had a deleterious effect on peripheral neuropathy with the post-treatment toxicity momentum markedly worse for GC80. Mean quality-adjusted life months were 6.1 on GC80, 5.6 on GC50 and 6.1 on GCb6.

Conclusion Although higher doses of cisplatin (80 mg/m2) are thought detrimental to QoL compared to 50 mg/m2 we found minimal differences but a noteworthy problem in delayed neuro-pathy. Also, the belief that carboplatin produces superior QoL compared to cisplatin at either dose is not obvious. Importantly carboplatin treatment may not palliate dyspnea as well as cisplatin. Adjusting for QoL does not change the conclusions from the primary survival analysis.
Abstract S90 Table 1

<table>
<thead>
<tr>
<th></th>
<th>Number having treatment (%)</th>
<th>OR (95% CI) vs no nurse/unknown</th>
<th>Patients surviving &gt;28 days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Seen by nurse</td>
<td>Not seen by nurse/unknown</td>
<td>All patients</td>
</tr>
<tr>
<td>Anti-cancer treatment</td>
<td>14 631 (64.5%)</td>
<td>3086 (40.4%)</td>
<td>2.04 (1.91 to 2.18)</td>
</tr>
<tr>
<td>Surgery</td>
<td>3456 (15.3%)</td>
<td>922 (12.1%)</td>
<td>1.06 (0.97 to 1.17)</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>7708 (34.0%)</td>
<td>1247 (16.4%)</td>
<td>2.05 (1.90 to 2.22)</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>7140 (31.5%)</td>
<td>1474 (19.3%)</td>
<td>1.57 (1.47 to 1.68)</td>
</tr>
</tbody>
</table>

S88  DAY CASE CISPLATIN DELIVERY FOR ADVANCED NSCLC: PATIENTS: FASTER, CHEAPER, MORE DESIRABLE

doi:10.1136/thoraxjnl-2011-201054b.88

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Background The BTOG2 trial was a phase III randomised clinical trial in the treatment of advanced NSCLC. It investigated the optimal dose of cisplatin (50 vs 80 mg/m² 3-weekly), in combination with gemcitabine, and whether carboplatin (AUC6-Wright) could safely and effectively be substituted for the optimal cisplatin dose. The protocol recommended cisplatin given as an out-patient regimen designed to ensure diuresis while maintaining electrolyte balance. A previously reported audit by these authors, 48% of hospitals surveyed were admitting NSCLC patients for cisplatin/gemcitabine chemotherapy.

Methods Between April 2005 and November 2009, 909 patients were randomised to receive cisplatin, in the UK and Ireland, as part of BTOG2. The trial mandated submission of proposed chemotherapy delivery schedules to ensure standard parameters in terms of: total duration of delivery, mandatory use of mannitol, short 1-h delivery of cisplatin and total fluid volume <4 l. Data mining was used to investigate AEs relating to renal function, electrolyte imbalance and ototoxicity. AEs that could feasibly be related to the manner in which cisplatin was administered.

Results 2853 treatment cycles were available for analysis. Average treatment duration decreased from nearly 9 to 6 h and total fluid volume from as much as 7 to <4 l. As a result of participating in BTOG2, 97% of surveyed hospitals were able to deliver cisplatin in a day case setting. Toxicities feasibly related to the manner in which cisplatin was administered were comparable to the current available literature with <1% experiencing grade ≥2.

Conclusion Current NHS Tariffs in the UK quote a 60% higher price for patients being inpatient cisplatin treatment as opposed to outpatient. With the prima facie case that patients prefer outpatient treatment, it is important to achieve the maximum benefit from the existing drugs in a clinically deliverable way. The results indicate that administering cisplatin via a short hydration schedule of <6 h, even at 80 mg/m², is safe. It is unlikely that the many hospitals who changed their practice would have done so without the support of a running randomised controlled trial.

S89  A META-ANALYSIS OF LIMITED RESECTION VS LOBECTOMY FOR STAGE I NON-SMALL CELL LUNG CANCER

doi:10.1136/thoraxjnl-2011-201054b.89

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WITHDRAWN

S80  NURSE SPECIALIST INPUT IS INDEPENDENTLY ASSOCIATED WITH ANTI-CANCER TREATMENT IN LUNG CANCER

doi:10.1136/thoraxjnl-2011-201054b.90

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Introduction Lung cancer nurse specialists (LCNS) provide an extremely important service to patients. Their skill and expertise are valued very highly by both patients and colleagues, but it has proven difficult to measure their input objectively, leading to a lack of expansion (and in some areas contraction) of the workforce. Earlier this year the National Lung Cancer Audit (NLCA) reported that for 2009, patients who saw an LCNS were more than twice as likely to...