radical in 42 pts (31.3%). Nineteen pts (13.9%) received concurrent CRT after neoadjuvant chemotherapy (CT). According to tumour type, 14 pts (10.2%) received platinum compounds, 81 (59.1%) fluoropyrimidines, 29 (21.1%) mytomycin C and fluorouracil or cisplatin and 5-fluorouracil, 7 pts (5.1%) received targeted therapy, 5 pts (3.6%) temozolomide and in 1 pt (0.8%) mytomycin C. RT was delivered with 3D-CRT (112 pts, 81.7%) and IMRT (25 pts, 18.2%) to a median dose of 57 Gy (range 11-70 Gy) with daily fractions of 1.8-2.5 Gy. Compliance to CRT, as treatment interruptions or dose modifications, was evaluated. KPS, CI and age were also considered, and their correlation with acute ≥ grade (G) 2 toxicity (CTCAE v.3 scale) was analyzed.

Results: Overall, 137 out of 10,251 pts (1.33%), 82 males (60%) and 55 females (40%), with median age 74 years (range 70-90) were analyzed. Scheduled CRT was completed by 132 pts (96.3%). Five pts (3.6%) definitively stopped CRT: 1 pt with gastric cancer had bowel obstruction; 1 pt with oesophageal cancer developed brain metastases; 1 pt with rectal cancer had G3 gastrointestinal toxicity; 1 pt with oesophageal cancer had G2 vomiting; 1 pt with oral cancer had G3 mucositis and refused treatment. Overall, 33 pts (25%) interrupted CRT: 7 (21.2%) both RT and CT and 26 (78.8%) only CT. Dose modification of CT was adopted in 16 pts (11.7%). Twenty-five pts (18.2%) developed haematological toxicity, ≥ G2 in 21 cases (84.0%). Gastrointestinal toxicity was observed in 55 pts (41.0%) and in 29 of them (53.0%) ≥G2. Genitourinary toxicity occurred in 13 pts (9.8%) and 8 of them (61.5%) had ≥G2. Mucositis was recorded in 19 pts (13.9%) and in 29 of them (79.0%) was ≥G2. No statistical significant correlation between KPS, CI, age and toxicity was found; we observed a trend for correlation between mucositis ≥G2 and age (p=0.05).

Conclusions: In our retrospective study, concurrent CRT for elderly pts in different cancer settings seems to be feasible with a good toxicity profile. Great attention in prescribing CT dose should be paid to limit acute toxicity.

Electronic Poster: Clinical track: Palliation / Supportive care / Patient support

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Nudge Theory: a cost-effective method for increasing resuscitation decision-making in oncology inpatients
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Purpose/Objective: Many in-hospital deaths involve cardiopulmonary resuscitation (CPR), often when it is unlikely to succeed. Of all patients undergoing CPR in UK hospitals, only 22% have their resuscitation status considered prior to cardiac arrest. Patients with cancer have a lower likelihood of benefitting from CPR than those without cancer, and the extent of cancer spread is inversely proportional to survival following CPR. For oncology inpatients, early documentation of escalation and resuscitation status reduces inappropriate CPR attempts by a factor of ten and intensive care unit referrals by a factor of three. Nudge theory is concerned with the subtle alteration of choice architecture, in order to effect positive change without significantly reducing the options available to decision-makers. This quality improvement project attempted to use a nudge theory-based intervention in order to increase the rates of CPR and escalation decision-making for oncology inpatients.

MATERIALS AND METHODS: Rates of resuscitation and escalation decision-making were recorded weekly from a representative selection of five sets of patient medical notes on an oncology inpatient ward from December 2013 to March 2014. In January 2014 the medical team’s ward list of patients was subtly altered: the column labelled ‘Blood results’ was changed to ‘CPR/ceiling’ (i.e. ceiling of treatment). The rates of documented decision-making were recorded weekly following this nudge intervention to assess its impact.

Results: Prior to the nudge intervention, rates of resuscitation and escalation decision-making ranged from zero to twenty percent. Following the nudge intervention, rates of documented decision-making steadily increased, until between eighty and one hundred percent of patients on the oncology ward had documented decisions about CPR and escalation.

Conclusions: The nudge intervention of changing the medical ward list, which represented a very small outlay in terms of cost and effort, led to a large increase in resuscitation and escalation decision-making for oncology inpatients. We believe that this dramatic effect can be replicated in other areas of oncology. Given how cost effective such interventions tend to be, we recommend further research into novel applications of Nudge Theory within oncology practice.

References: