and during therapy Hb appear to be associated with fatigue, poorer quality of life (QoL), and increased hospitalization.

**Methods:** This is a multi-centre prospective cohort study in completely resected primary NSCLC patients who are scheduled to receive 4-6 cycles of platinum-based adjuvant chemotherapy. Patients are to be followed throughout their entire treatment period to assess anaemia rates and document anaemia management, as well as identify prognostic factors for anaemia development. Long-term outcome assessments are currently ongoing.

**Results:** As part of an interim analysis, 115 patients enrolled into the study were assessed. Mean age was 63.5 years and 52% of patients were female. Mean baseline hemoglobin (Hb) was 132.8 g/L. Less than 20% patients had a Hb of ≥120 g/L at the onset of adjuvant chemotherapy. During chemotherapy, 101 patients (87.8%) developed moderate anaemia as defined a priori in the protocol as a Hb ≤120 g/L or a Hb drop of ≥20 g/L. Furthermore, 40 patients (34.8%) had a Hb of <100 g/L and 56 patients (48.7%) had a Hb of 100-120 g/L during chemotherapy. Time to development of moderate anaemia was observed in greater than 75% of patients by the end of Cycle 1. As data collection is ongoing, data relating to anaemia treatment on study is limited to 90 patients. In this subset, 19 patients (21.1%) received red blood cell transfusions, while only 13 patients (14.4%) reported receiving an erythropoietic agent.

**Conclusions:** In an interim analysis of 115 NSCLC patients receiving adjuvant chemotherapy, it was observed that 88% of the patients developed anaemia as defined above, with a statistically strict confidence interval of 12%. Time to development of anaemia in the majority of the patients occurred early in their chemotherapy regimen. As such, erythropoietic intervention in this patient population may prove beneficial. Final analyses will include data from approximately 130 patients, including transfusion use, chemotherapy data and QoL data. Future research is required to confirm the impact of anaemia management on patient outcomes.

**P1-250**

**Barriers for accrual to clinical trials in adult patients (pts) with non-small cell lung cancer**

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**Background:** Despite recent advances in the treatment of pts with non-small cell lung cancer (NSCLC), the outcome continues to be poor. Only about 3% of all adult oncology pts enroll in clinical trials compared to approximately 50% of pediatric pts. The proportion of adult pts enrolled in clinical trials is low, even in tertiary cancer centers. It is critical to understand the barriers for accrual to clinical trials.

**Methods:** We reviewed the outpatient charts of all pts with NSCLC referred to the thoracic medical oncology group at our institution from 1/1/2006 to 12/31/2006. Available and appropriate clinical trials were presented to the pts routinely and reasons for non-enrollment were documented. We collected information on histology, stage, performance status (PS), and co-morbid conditions. Appropriate studies at the time of initial consultation were noted from the cancer center database.

**Results:** Of 272 consecutive patient charts reviewed, 13 pts (4.8%) did not require therapy and 26 pts (9.6%) had already initiated therapy at the time of the consultation. Of the remaining 233 evaluable pts, 51 pts (21.9%) were not enrolled because of lack of available appropriate clinical trials at the time of initial consultation, the most common reason being lack of available studies for adjuvant therapy. Twenty-four pts (10.3%) enrolled onto a clinical trial. The most common reasons for not being enrolled in a clinical trial included: ineligibility due to poor PS (32 pts, 13.7%), need for emergent radiotherapy (20 pts, 8.6%), patient refusal (14 pts, 6.0%), geographic issues (10 pts, 4.3%), and insurance issues (10 pts, 4.3%). Three pts (1.3%) were lost to follow-up.

**Conclusion:** Poor performance status is the most common reason for non-enrollment onto a clinical trial.

**P1-251**

**Supportive Care/QOL Posters, Mon, Sept 3**

**Skin toxicities difference between erlotinib (E) and gefitinib (G) in the treatment of advanced non-small-cell lung cancer (NSCLC)**

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**Background:** Cutaneous toxicities due to E or G are common and reversible adverse effects. In the two large randomized trials with E (Shepherd F et al, NEJM 2005) and G (Thatcher N et al, Lancet 2005) skin rash toxicity incidence seems different between the two drugs: all grades (gr) were observed in 76% and 37% of patients (pts), gr 3-4 in 9% and 2% respectively. The aim of this study was to assess the incidence of the most common toxicities occurred in a cohort of pts treated with E or G in the same period of time and evaluated by the same medical staff according to the Common Toxicity Criteria version 3.0.

**Methods:** From May 2005 to July 2006, 47 pts suitable for a treatment with an EGFR inhibitor were evaluated for their eligibility in an expanded access program (EAP) with E 150 mg/day. Pts ineligible for the EAP (16) were treated with G 250 mg/day in a compassionate-use program. Fifteen pts were treated with G at progression after E.

**Results:** Toxicities (all gr, gr 3/3-4) for E vs G consisted in: acneform rash (64 vs 25%, 13 vs 0%), rash/desquamation (83 vs 19%, 12 vs 0%), pruritus (38 vs 16%, 6 vs 0%), dry skin (48 vs 32%, 3 vs 0%), nail changes (15 vs 6%, 3 vs 0%), diarrhea (54 vs 19%). When pts were treated with both E and G the toxicities (all gr, gr 3/3-4) observed were: acneform rash (93 vs 20%, 27 vs 0%), rash/desquamation (100 vs 20%, 20 vs 0%), pruritus (41 vs 13%, 7 vs 0%), dry skin (54 vs 27%, 7 vs 0%), nail changes (27 vs 7%, 7 vs 0%), diarrhea (53 vs 7%).

**Conclusions:** Our data suggest that there are less cutaneous adverse effects with G. This difference may be probably attributed to the dose of E three times greater than the G dose.

**P1-252**

**Supportive Care/QOL Posters, Mon, Sept 3**

**Epoetin beta treatment for anemia in lung cancer patients under chemotherapy: results of a large prospective cohort study**

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