The clinical validity and responsiveness of the QLQ-BM22 was tested by known group comparisons of different performance status and response to radiotherapy.

Results: Two hundred and four patients completed both questionnaires at baseline and follow up. On multitrait scaling analysis, there was evidence of construct validity, likely explained by the format of the questionnaire and population characteristics. There was little correlation between most QLQ-BM22 and QLQ-C15-PAL items, except for the conceptually related scales. There were statistically significant differences in all QLQ-BM22 scale scores in groups with KPS < 80 versus KPS ≥ 80 and three out of four QLQ-BM22 scale scores in “responders” versus “non-responders” to radiotherapy. In patients who responded to radiotherapy, there were statistically significant differences in all QLQ-BM22 scale scores between baseline and follow up.

Conclusions: This study further validates the use of the QLQ-BM22 as a robust and sensitive instrument to assess QOL in patients with bone metastases treated with palliative radiotherapy.

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MINIMAL CLINICALLY IMPORTANT DIFFERENCES IN THE EORTC QLQ-BM22 AND EORTC QLQ-C15-PAL MODULES IN PATIENTS WITH BONE METASTASES
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Purpose: Patients diagnosed with WT in low and middle income countries face many incremental challenges compared to those diagnosed in high income countries. The objectives of our study are: 1) to describe patient outcomes in Ghana; and 2) to identify opportunities for improvement.

Methods and Materials: Methodology Retrospective chart review was undertaken supplemented by telephone follow up to ascertain disease status and adverse effects. Patients who are ≤ 14 years, diagnosis with WT that is histologically confirmed between January 2005 - December 2014, treated with curative surgery with or without adjuvant RT at our institution were eligible.

Results: One hundred and one patients were identified. Median age was 56 (range 1-168) months and median follow up was 38 (range 1-86) months. Staging imaging consisted of ultrasound in the early years and CT scan since 2012. Fifty-seven patients presented with advanced Stage (clinical Stage I 0, II 42, III 25, IV 31, stage not available 3). All patients were treated with neoadjuvant chemotherapy (Vincristine, Actinomycin D + Adriamycin) followed by radical nephrectomy (99), except two had upfront surgery. At surgery, advanced stage was found in 73% (pathologic Stage I 0, II 29, III 58, IV 14, V 1). Forty-five patients were referred for radiotherapy with positive margins (14), positive lymph nodes (eight), residual disease (five), peritoneal spillage (seven) and unfavourable histology (11). Ten patients did not report for RT. Mean interval from surgery to RT was 36.6 days. 2D technique (APPA fields to the flank or whole abdomen) with 10.8-21.6 Gy in 6-12 fractions was used. Thirty-three patients completed RT without interruptions. Acute Grade 2 toxicities for the RT group included: diarrhea (seven) and vomiting in (nine). Late side effects included intestinal obstructions (two), chronic renal disease (one) and cardiomyopathy (one). Site of first recurrence was within the radiation field (five) and distant metastasis (two). Two-year OS and DFS were 56% and 44% respectively. Two-year OS for the whole group was 31% and 39% respectively. Main reasons for interruption were monetary.

Conclusions: WT patients in Ghana have more advanced pathological stage than clinical stage despite neoadjuvant chemotherapy. This is attributable to suboptimal pre-operative staging. The interval between surgery and RT is long. Quality improvement strategies including uniform provision of CT-scan for staging and reduction in the interval between surgery and RT is achievable in our current practice environment and expected to improve outcomes. This is urgently needed.