with clinical events (disease progression or tumor response) or changes in patient functioning (i.e., performance status).

Methods: Eighty patients with advanced NSCLC (median age = 70.5 years) were prospectively studied during the first 12 weeks of their chemotherapy. Eligibility criteria included diagnosis of new or recurrent stage III or IV NSCLC, initiation of chemotherapy (any line), over age 18, comprehension of English, and no substantial cognitive or physical impairments. Symptoms were assessed weekly through telephone administration of the Functional Assessment of Cancer Therapy Lung Symptom Index-12 (FLSI-12), a brief, reliable and valid symptom measure for advanced lung cancer, with items scaled from 0 (not at all) to 4 (very much). Based on FLSI-12 item scores, all patients were at least slightly symptomatic at baseline. Data on Eastern Cooperative Oncology Group performance status (PS) were collected from patients every three weeks during clinic visits. At baseline, most patients (83%) rated themselves PS 0 (normal activity) or PS 1 (symptomatic, fully ambulatory). Symptom reports were mapped onto on-study clinical events (progression or response) and PS assessments. Disease progression and tumor response were determined by clinicians from radiological evidence using RECIST criteria.

Results: Several symptoms worsened in association with disease progression and declining PS. Disease and chemotherapy-related symptoms, such as, pain, shortness of breath, cough, weight loss and appetite loss worsened most with disease progression. Patients responding to chemotherapy reported more fatigue and difficulty breathing at response than immediately before it. However, unlike the patients who progressed, patients responding to chemotherapy never or rarely complained of pain, weight loss, cough, chest tightness, nausea, or confusion before, during, or after response. Symptoms most associated with changes in PS were fatigue, weight loss, nausea, and appetite loss. For these, declining PS was associated with considerably more symptom worsening than unchanged or improving PS. However, pulmonary symptoms (shortness of breath, cough, chest tightness, difficulty breathing) were less clearly associated with changes in PS.

Conclusions: This study provides some direction that pulmonary symptoms and other general symptoms such as pain, loss of appetite and weight loss are most closely associated with disease progression. Patients responding to chemotherapy are less likely to have worsening of their pulmonary symptoms. A larger study may definitively identify changes in disease symptoms associated with disease progression and overall survival. Such information could assist clinicians in monitoring patient status on treatment and possibly investigate and modify treatment depending on changes in symptom profile.

P1-269 **Supportive Care/QOL Posters, Mon, Sept 3**

Analysis of some clinical parameters and survival, using the information provided by NSCLC patients through a questionnaire

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Background: Some factors such as age, stage and PS may provide prognostic information in advanced NSCLC; however, a better understanding of a patient's judgement can help the Physician to make appropriate decisions.

Purpose: 1- To study the information provided by pts in a questionnaire. 2 To study PS evolution obtained by the doctor (DPS) and by the pts themselves (PPS).3-To evaluate the correlation between some different variables with survival.

Patients and Method: 248 pts with stages III and IV NSCLC, age range 38 - 74 years, were studied. The study was prospective. Pts underwent chemotherapy and/ or radiotherapy. They determined their own PS through a questionnaire. Some different variables such as age, stage, DPS, PSP, appetite, food intake, amount of solid food, evening meals, average meal per day, serving size, vomiting frequency, daily work activity, activity restrictions, and hours of rest per day were analyzed. DPS and PPS were studied at diagnosis and at 3 months. Statistical methods: Cox Proportional-Hazards Regression, Chi Square Pearson, Irwin-Fisher, Wilcoxon tests and Kaplan Meier Curves were used.

Results: According to the univariate logrank test applied to the comparison of the Kaplan and Meier survival curves, many factors seem to be related to survival.The correlation among predictor variables is not taken into account when using the univariate approach, so a Cox model for the proportional risk was fitted using all the predictor variables available. A stepwise model selection was applied. It was found that only initial WL and DPS at the third month of evaluation were positively related to the risk of death.

Conclusion: Although the univariate approach showed that many factors are related to the survival of patients, the simultaneous analysis of these factors through the Cox model revealed that few of them summarize the most relevant prognostic information. These variables are DPS at the third month of evaluation and initial WL.

P1-270 **Supportive Care/QOL Posters, Mon, Sept 3**

Health Economics of Lung cancer care in rural/tribal areas. Role of Community-NGO's

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Objectives: NGO's are close to rural coomunities than City-based hospitals. Cost of running a NGO far less than medical institution. Cost of anti-ancer drugs is debatable at many forums. Pharma co's dont give substantial discounts to patients. In resource poor setting unaffordable cost leads to poor therapeutic compliance & high mortality. This Cost hurdle was overcome using our Community-NGO based model. It provides cost-effective methodology. We need to establish common strategy to develop of sound & sustainable cancer care programs avaialble to rural communities

Methods: Our NGO volunteers have strength of 24. cost of chemo-Radio therapy is beyond reach of common people in developing nations. Chemotherapy treatment in ci6ty speciality hospitals is unaffordable. No national program for financial help to lung cancer patients available. Some NGO's's do offer little psychosocial support & subsidised treatment options. But such efforts are not cohesive. I lead team to conduct small seminars to mobilise community NGO's support for Lung cancer patients. We work for 10 hours per week free of cost to help poor patients for treatment access [illeterate poor patients from villeges need guidance & little finacial help]. Depending on support given by corporates & few local donors we give these poor people little financial assistance to cover treatment cost. We help these patients in getting access to governmental hospitals, till today our NGO covered 9 villages supporting 64 lung cancer sufferers.

Results: We did face hiccups in mobilising volunteers & resources. We now have five local community NGO's integrated program. These can-