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The development of a practice guideline for the management of malignant thymoma through a formal consensus process.

Evans, William K.1 Malthaner, Richard A.2 Gregg, Richard3 Maziac, Donna E.4 Darling, Gail5 Falkson, Conrad6 Yu, Edward7

1 Juravinski Cancer Centre, Hamilton, ON, Canada 2 London Health Sciences Centre, London, ON, Canada 3 Cancer Centre of Southeastern Ontario, Kingston General Hospital, Kingston, ON, Canada 4 University of Ottawa, Ottawa General Hospital, Ottawa, ON, Canada 5 University Health Network, Princess Margaret Hospital, Toronto, ON, Canada 6 Cancer Centre of Southeastern Ontario, Kingston General Hospital, Kingston, ON, Canada 7 University of Toronto, Toronto, ON, Canada 8 Queens University, Kingston, ON, Canada

Background: Due to the low incidence of thymoma, there is little high-quality evidence on the clinical management of thymoma. Much of the evidence consists of small retrospective case series. As a result, in 2006, a working group of the provincial Lung Disease Site Group undertook a formal consensus process to develop a guideline for the management of malignant thymoma through Cancer Care Ontario’s Program in Evidence-based Care (PEBC).

Methods: The consensus process followed a traditional evidence-based guideline development process, beginning with a systematic search of the literature and a review of evidence. Members of the DSG reviewed the studies available from 1996 onwards and met in two teleconferences to draft preliminary recommendations. A modified-Delphi formal consensus process was then undertaken. The draft recommendations were distributed as a survey to a sample of relevant clinicians from across Canada (n=68) for two rounds of response. Round one entailed respondents reviewing a brief evidence summary, with instructions to rate their degree of agreement or disagreement (scale 1 to 7, 1 = strongly agree, 7 = strongly disagree) for each of the 38 thymoma management recommendations proposed by the Lung DSG working group.

Results: In Round One, responses were received from 32/68 (47%) of individuals surveyed. Of the 38 recommendations, 9 were identified as having significant variability in agreement amongst reviewers. In Round Two, a statistical and graphical representation of results from Round One were distributed, and respondents were asked to re-rate their agreement with recommendations, in consideration of the group responses. For some items respondents articulated possible changes to the recommendations in their written feedback. These were incorporated in the Round Two questionnaire as ‘options’, and respondents were asked to identify their agreement with the original and with the modified second recommendation.

Conclusion: The results from Round Two are pending; the working group will reconvene via teleconference to confirm that issues of prior disagreement have been appropriately addressed, and/or made explicit in the final report. Final consensus guideline recommendations will be presented.

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Asbestos and mesothelioma in Egypt

Gaafar, Rabab M.

Medical Oncology, Cairo, Egypt

Background: The widespread use of asbestos during the 20th century has produced a legacy of ill-health, death and contamination which will endure well into the current century. Epidemics of asbestos illness have been reported in industrialized countries for many years; now, data are being collated which document an escalation of these diseases in developing countries such as Brazil, Thailand and Egypt.

Asbestos manufacturing began in Egypt more than 50 years ago. By 2004, there were 14 asbestos factories employing thousands of workers. Asbestos is imported from Russia and Canada and is used for the manufacture of asbestos-cement pipes, roofing and wall materials, valves, joints, sealants, clothing, cords, strings, clutches, brake linings and pads; crocidolite and amosite were used in pipes and corrugated sheets until fairly recently. The working conditions in these factories were poor and included occupational exposure to various asbestos types on a daily basis.

Methods and Results: In the first 5 years of the 3rd millennium (2000-2004), 832 cases of mesothelioma were diagnosed at NCI, and Abbassia Chest Hospital, Cairo. Both hospitals drain and serve most of the high risk population living in the neighborhoods of the oldest asbestos production plants. Median age was 53 (19-90) years. Females represented 39.2% and young adults ≤ 40 years represented 19.1%. Residential exposure was evidenced in 64.7% of cases (Shobra El-khema, 35.6%, El-Maasara and surrounding area 23.6%, El Zyytoon 5.2%, and others 0.5%). Twenty five percent came from other Cairo areas and 9.8% from other governorates. The NCI hospital based-registry showed an increase in the relative frequency of MFM from 0.47% in 2001, to 1.4% in 2004.

In a trial to find a relation between residency and asbestos exposure, a field study was done to investigate the residential areas surrounding the oldest factory in El-Maasara, Cairo. Heaps of asbestos wastes with breaks of cement pipes and sheets were visualized outside the fence of the factory, improperly disposed off. Repeated airborne asbestos samples were collected using National Institute for Occupational Safety and Health (NIOSH) method No 7400. Results showed the presence of asbestos fibers in those residential areas in counts ranging from 0.002 f/cc, 7 kilometers from the factory, to levels beyond permissible exposure limits (PEL), increasing awareness of the public regarding the risk of asbestos exposure, education and protection of Egyptian asbestos workers, follow up and if possible periodical medical checks for population at risk of occupational and/or residential exposure.

Conclusion: There is a clear need for stronger legislative measures to eliminate asbestos entirely in order to combat the coming epidemic of mesothelioma in Egypt.

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Tissue and serum EGFR as prognostic factors in malignant pleural mesothelioma

Gaafar, Rabab M.1 Bahnassy, Abeer A.2 Abdel-Salam, Ibrahim1 Helal, Amani1 Abdelrahman, Abdelrahman1 Hassan, Nelly3 Ismail, Hoda4 Mokhtar, Nadia6

1 Medical Oncology, NCI, Cairo, Egypt 2 Molecular Pathology, Cairo, Egypt 3 Biochemistry, Cancer Biology Dept., NCI, Cairo, Egypt 4