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-- PRESS BRIEFING SUNDAY, JUNE 3, 7:30 AM CDT --

NEW INSIGHTS INTO PATTERNS OF CANCER CARE

**-- Studies Examine New Treatments and Access to Care for Children with Cancer;
Growing Gap Seen in Advanced Breast Cancer Survival between
Black and White Women;
Prostate Cancer Patient Treatment Decisions Influenced by Type of Specialist
Consulted --**

CHICAGO—Studies evaluating patterns of care for cancer patients were released today at a press briefing of the 43rd Annual Meeting of the American Society of Clinical Oncology (ASCO).

“We’ve made great progress in treating cancer—but we still have work to do to make sure that everyone benefits from those advances,” said Archie Bleyer, MD, medical advisor in the Cancer Treatment Center at St. Charles Medical Center, Bend, Ore., and moderator of the press briefing. “It is important that we maintain our focus on improving access to cancer care and ensure that all patients, regardless of age, race, ethnicity or geography receive the most appropriate treatment.”

Study findings include:

- Several studies on childhood cancer, including:
 - A long-term study of childhood cancer survivors finds that even though they are known to be at risk for long-term health problems, most do not receive specialized medical care to monitor their health over the years.
 - A study of infants and children with neuroblastoma shows that they can be treated with significantly less aggressive chemotherapy and still achieve high survival rates.

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- A report on a program to fight childhood cancer in low- and middle-income countries shows that even small monetary investments can help improve children's treatment and build local cancer care capacity.
- A survey of parents of children with cancer finds that those who get more detailed information about their child's prognosis feel more hopeful, even if the prognosis is poor.
- An analysis of women with advanced breast cancer over the past two decades finds that disparities in survival between black and white patients have increased, with improvements in breast cancer-specific survival seen only among white women.
- A study finds a strong association between the type of physician that men with localized prostate cancer see and the kind of therapy they choose to receive, reinforcing the need for patients to have access to the full range of information before choosing a particular therapy.

For consumer-oriented information on these studies and more than 120 cancer types and cancer-related syndromes, please refer your readers to ASCO's oncologist-vetted patient Web site, www.plwc.org.

This study is embargoed for release until 7:30 AM CDT, Sunday, June 3.

**CLINICAL SCIENCE SYMPOSIUM
SUNDAY, JUNE 3, 2:45 PM CDT
E ARIE CROWN THEATER**

**Lead Author:
Paul C. Nathan, MD
Hospital for Sick Children
Toronto, Canada**

Most Survivors of Childhood Cancer Don't Get Recommended Follow-Up Care

A large, ongoing study has found that even though survivors of childhood cancer are known to be at significant risk for long-term health problems, the majority of them do not receive specialized medical care over the long term.

Previous studies have found that approximately two-thirds of childhood cancer survivors develop at least one chronic health condition as a result of their cancer or cancer treatment. These health conditions include secondary cancers, heart problems, lung disease, stroke and premature menopause.

This is the first study to look in detail at long-term health care utilization among childhood cancer survivors. Study participants were members of the Childhood Cancer Survivor Study, a U.S. National Cancer Institute-sponsored research program that follows children who survived at least five years after being diagnosed with cancer between 1970 and 1986.

In the study, 8,522 survivors completed a questionnaire about the health care they had received within the previous two years. The median age of participants was 6.8 years when they were diagnosed with cancer and 31.4 years when they were surveyed. Health care experience was classified in the study as general care, cancer-related care (medical care directly related to prior cancer diagnosis or treatment) and risk-based cancer-related care (care to proactively manage the long-term health risks of cancer and its treatment). A subgroup of risk-based cancer-related care was defined for patients at substantial risk for cardiac problems (those who received high doses of anthracycline chemotherapy or any dose of anthracycline plus chest radiation) or breast cancer (those who received chest radiation and those older than 27).

The researchers found that 88 percent of those surveyed reported some type of medical care in the previous two years. Fourteen percent reported receiving cancer-related care and 18 percent receiving risk-based care. Among patients at increased risk for cardiac problems or breast cancer, just 28 percent and 49 percent reported having received an echocardiogram or mammogram, respectively. However, current guidelines recommend that all cancer survivors at risk of cardiac disease have an echocardiogram every one to two years and those at risk of breast cancer have a mammogram every year starting at age 25.

“We were disappointed by these findings,” said Paul Nathan, MD, a staff oncologist at the Hospital for Sick Children in Toronto and the study’s lead author. “Breast cancer and cardiac problems are conditions that, while not entirely preventable, are treatable if they are picked up early. But we found that the majority of patients are not getting the tests they need to be diagnosed in a timely manner.”

The authors say it is important for all survivors of childhood cancer to be aware of their increased health risks and for physicians, especially primary-care doctors, to know which tests and exams they should offer patients who are cancer survivors.

***6502**

Risk-based care in survivors of childhood cancer: A report from the Childhood Cancer Survivor Study (CCSS)

P. C. Nathan, M. L. Greenberg, K. K. Ness, M. C. Mahoney, J. G. Gurney, M. M. Hudson, S. S. Donaldson, W. M. Leisenring, L. L. Robison, K. C. Oeffinger

Background: Childhood cancer survivors are at significant risk of morbidity as a result of their therapy. Thus, they require regular medical follow-up focused on their specific long-term risks. We examined the frequency and type of care received by a cohort of adult survivors of childhood cancer and examined the predictors of the receipt of appropriate risk-based care. **Methods:** Eligible subjects were members of the CCSS, a multi-institutional study of patients who have survived at least 5 years after being diagnosed with childhood cancer between 1970 and 1986. Participants completed a baseline survey and a subsequent survey on health care contact within the preceding 2 years. Contact was classified hierarchically as general care, cancer-related care, basic risk-based care and optimal risk-based care. Optimal risk-based care was assessed only in patients whose therapy is associated with a substantial risk of cardiac disease ($\geq 300 \text{ mg/m}^2$ of an anthracycline, or any anthracycline plus chest radiation) or breast cancer (females who received chest radiation who are ≥ 27 years). Univariate and multivariable analyses were performed to assess associations between demographic/treatment variables and health care outcomes using logistic regression models. **Results:** The health care questionnaire was completed by 8448 survivors. Median age (range) at diagnosis was 6.8 (0-21.0) years and at assessment was 31.4 (17.5-54.1) years. 87% reported general medical contact, 31% cancer-related care and 12% basic risk-based cancer care. Amongst patients at increased risk of cardiac disease (N=1798) or breast cancer (N=852), only 28% reported receiving an echocardiogram and 49% a mammogram, respectively. Patients without health insurance (odds ratio [OR]=2.22, 95% confidence interval [CI]=1.56-3.13, $p < 0.0001$ by Wald statistic), males (OR=1.19, 95% CI=1.03-1.37, $p=0.02$), younger patients (OR=1.03, 95% CI=1.02-1.04, $p < 0.0001$) and those who perceived their health as good/excellent (OR=1.37, 95% CI=1.13-1.65, $p=0.001$) were at increased risk of not having received basic risk-based care. **Conclusions:** Despite a significant risk of late effects after cancer therapy, the majority of adult survivors of childhood cancer do not receive appropriate risk-based health care.

Disclosures for Research Team: Nothing to disclose.

This study is embargoed for release until 3:00 PM CDT, Saturday, June 2.

**ORAL PRESENTATION
SATURDAY, JUNE 2, 3:00 PM CDT
ROOM E450a**

**Lead Author:
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Perth, Australia**

Less Intense Treatment for Children with Advanced Neuroblastoma Achieves High Survival Rates

Results of a multi-institutional phase III trial have shown that infants and children with neuroblastoma can be treated with significantly less aggressive chemotherapy than has been typically used and still achieve survival rates higher than 90 percent.

Neuroblastoma is a relatively rare pediatric cancer of the sympathetic nervous system that typically begins in one of the adrenal glands. Although survival rates are generally high with the current standard treatment, it can have long-lasting side effects, including kidney and heart damage and hearing loss.

“This is an important treatment advance—while it appears to achieve similarly high survival rates seen with other, more intensive treatments, it will be much easier on patients,” said David Baker, MBBS, director of the pediatric and adolescent hematology-oncology program at Princess Margaret Hospital in Perth, Australia, and the study’s lead author. “The paradigm that we are continually striving for is to cure as many children as possible while reducing the burden of treatment and leaving them with as few long-term side effects as possible. This goes a long way toward meeting that goal.”

The study was conducted by the Children’s Oncology Group, a cooperative organization of physicians and institutions in the United States, Canada, Australia and New Zealand. The study included 362 infants under 12 months old with advanced disease and 105 children over 12 months old with regional disease. While this study did not directly compare the new, less intensive treatment with the old standard, more intensive treatment, the study’s primary objective was to determine if the overall survival rate of 90 percent or greater that is typically seen in this group of patients could be achieved with significantly lower chemotherapy doses.

Patients in the current trial received fewer rounds of chemotherapy over a shorter length of total treatment time (10 to 18 individual days of treatment over 84 to 168 days) than the current standard treatment (71 days of treatment over 286 days). Four of the most active chemotherapy drugs against neuroblastoma were used and researchers substituted cisplatin, one of the drugs normally used, with carboplatin. Cisplatin has been associated with high rates of long-term side effects, especially hearing loss.

With an average follow-up time of three years, the overall survival rate for all patients in the study was 96 percent, a rate equivalent to or better than that seen in large trials of the standard treatment. Major toxicities to the heart, kidney, liver and hearing were all less than 2 percent, significantly less than those experienced with standard therapy.

***9504**

A phase III trial of biologically-based therapy reduction for intermediate risk neuroblastoma
D. L. Baker, M. Schmidt, S. Cohn, W. B. London, A. Buxten, A. Sandler, H. Shimada, K. Matthey

Background: Infants with advanced neuroblastoma (stage 3 and 4) and children >1 year with favorable biology stage 3 disease have had a survival exceeding 80% with aggressive chemotherapy. The primary objective of Childrens Oncology Group A3961 was to maintain a 3-year event-free and overall survival rate above 90% for intermediate risk (IR) neuroblastoma with a reduction in therapy compared to historical trials for similarly defined risk patients. **Methods:** IR patients were defined by selected clinical (age, INSS stage, histopathology) and biologic (MYCN status and DNA index) factors. All eligible IR patients were MYCN non-amplified and were divided into subcategories defined as favorable or unfavorable biology. Therapy consisted of 2 to 3 agent combinations of carboplatin, etoposide, cyclophosphamide and doxorubicin given every 3 weeks for a total of 4 cycles (favorable biology) or 8 cycles (unfavorable biology). Patients with favorable biology failing to achieve CR/VGPR

after 4 cycles and surgery, received 8 cycles. All patients were required to enter a companion neuroblastoma biology study and to enroll on A3961 within 28 days of diagnosis. **Results:** Between March 1997 and May 2005, 467 eligible patients were enrolled on study. These included 261 stage 3 (105 children; 156 infants), 174 stage 4 infants, and 32 stage 4s infants. 362 (78%) were less than 12 months of age at diagnosis. 330 (71%) patients had favorable and 137 (29%) unfavorable biology. There were 40 (12.1%) of 330 favorable biology patients who went onto cycles 5-8. There were 52 events in 467 cases including 15 deaths and two secondary AML. **Conclusions:** The primary hypothesis of this study was confirmed and survival rates greater than 90% were maintained for IR neuroblastoma with reduced therapy compared to historical trials. The successor trial will prescribe duration of therapy based, in part, on loss of heterozygosity states at 1p36 and 11q23 as well as initial response to treatment in an endeavor to further reduce therapy for this group of patients.

Cohort	n	3-year EFS ± std error (%)	3-year OS ± std error (%)
Overall	467	88 ± 2	96 ± 1
Favorable biology	330	90 ± 2	98 ± 1
Unfavorable biology	137	83 ± 3	94 ± 2
Stage 4 infants	174	82 ± 3	93 ± 2
Unfavorable biology Stage 4s infants	32	89 ± 6	97 ± 3
Stage 3	261	92 ± 2	98 ± 1
Stage 3 infants	156	96 ± 2	98 ± 1
Stage 3 children	105	88 ± 3	99 ± 1

Disclosures for Research Team: Nothing to disclose.

This study is embargoed for release until 7:30 AM CDT, Sunday, June 3.

**POSTER PRESENTATION
SUNDAY, JUNE 3, 2:00 PM CDT
ROOM S Hall A2
POSTER DISCUSSION
SUNDAY, JUNE 3, 5:00 PM CDT
ROOM E450a**

**Lead Author:
Raul C. Ribeiro, MD
St. Jude Children's Research Hospital
Memphis, Tenn.**

Small Investments Can Improve Childhood Cancer Treatment in Low- and Middle-Income Countries

Initial results of a program to fight childhood cancer in low- and middle-income countries show that relatively small monetary investments in a range of different projects can help improve treatment for children with cancer. The program, My Child Matters, was created by the Geneva-based International Union Against Cancer and the pharmaceutical firm sanofi-aventis, with additional funding from the U.S. National Cancer Institute.

Due to significant advances in treating and curing pediatric cancers over the past several decades, the average survival rate in developed countries is now 80 percent. However, most children with cancer live in low- and middle-income countries, where misdiagnosis, late diagnosis, lack of access to treatment and early termination of treatment have greatly deterred progress. As a result, the average survival rate is only about 20 percent.

The program analysis showed that after one year, many of the projects' short-term goals were met, including improved patient care infrastructure, public and professional education, earlier detection, improved access to care, the introduction of psychosocial support, decreased abandonment of treatment and better follow-up.

"This is an incredible partnership and a unique alliance among public and private organizations in several developed countries," said Raul C. Ribeiro, MD, director of the international outreach program at St. Jude Children's Research Hospital, a member of the program's steering committee and the study's lead author. "The disparities in pediatric cancer rates between developed and developing countries are unacceptable and unnecessary. Our program is showing that with tiny investments, we can make a big difference in the lives of children with cancer, even in the most impoverished settings. It is our hope that the results of these pilot projects can provide models for other countries to follow."

The first phase of the program included 14 pilot projects in 10 countries: Bangladesh, Egypt, Honduras, Morocco, Philippines, Senegal, Tanzania, Ukraine, Venezuela and Vietnam. The projects addressed the specific needs of each country by focusing on issues such as lack of follow-up care and palliative care, low awareness about the early warning signs of cancer, and the need for better access to diagnostics and treatment for cancers that are prevalent in specific geographic areas and easily curable with minimal therapy. Each project received up to 50,000 euros (about \$67,000) per year.

Funding was used to train local physicians and for medical supplies, equipment and other resources. The success of each project was measured based on the specifics of each program. Based on these findings, the program has now funded additional projects in Bolivia, Indonesia, Kenya, Mali, Peru and Romania.

***9526**

My child matters program: A UICC-Sanofi-Aventis partnership to improve pediatric cancer care in developing countries

R. C. Ribeiro, T. Eden, J. Hartford, J. Lemerle, I. Magrath, H. Sancho-Garnier, E. Steliarova-Foucher, G. Thaxter, I. M. Tabah-Fisch, F. Cavalli

Background: Despite dramatic advances in curing childhood cancer in developed countries, most children with cancer live in low-income countries, where misdiagnosis, late diagnosis, lack of access to treatment and abandonment of treatment hinder progress. **Methods:** In 2004 the International Union against Cancer and Sanofi-Aventis initiated a campaign to improve childhood cancer care in developing countries through

grants for local projects (up to 50,000 euros/year each), a survey of childhood cancer care (conducted by the public health consulting firm Sanisphere), and lobbying to increase political support. The projects focus on professional education, improved access to care, pain management, and psychosocial/educational support. **Results:** During 2006, 14 pilot projects in Bangladesh, Egypt, Honduras, Morocco, Philippines, Senegal, Tanzania, Ukraine, Venezuela, and Vietnam were selected on the basis of feasibility, expected benefit, sustainability, and potential to serve as models. Only eight countries had pediatric hematology/oncology units, ranging from 20 (Tanzania) to 350 (Egypt) beds. These units manage 100 (Senegal) to 1,000 (Bangladesh) children with cancer per year (a small fraction of actual cases in these countries). One-year outcome analysis showed that various short-term objectives were met, including improved patient care infrastructure, public and professional education, earlier detection, improved access to care, the introduction of psychosocial support, decreased abandonment and better follow up. On the basis of these results, 12 additional projects have been funded in Bolivia, Indonesia, Kenya, Mali, Peru and Romania. **Conclusions:** Relatively small investments, accompanied by external mentoring, can help build sustainable capacity for the diagnosis and care of children with cancer in selected institutions in developing countries

Disclosures for Research Team: Nothing to disclose.

This study is embargoed for release until 7:30 AM CDT, Sunday, June 3.

**ORAL PRESENTATION
MONDAY, JUNE 4, 7:30 AM CDT
ROOM S504**

**Lead Author:
Jennifer W. Mack, MD
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Receiving Child's Cancer Prognosis Increases Hopefulness of Parents

[Note: This summary contains updated data not in the abstract.]

A survey of parents whose children have been diagnosed with cancer has found that parents who get more detailed information about their child's prognosis feel more hopeful, even if the prognosis is poor.

“Evidence shows that physicians generally avoid providing information about a child's likelihood of being cured, for fear of destroying parents' hope,” said Jennifer W. Mack, MD, MPH, an attending physician at the Dana-Farber Cancer Institute and the study's lead author. “We found that not only can physicians communicate this information to parents without causing undue distress, honest disclosure about a child's prognosis may even enhance hope.”

The researchers surveyed 194 parents whose children were in their first year of cancer treatment at Dana-Farber Cancer Institute and Children's Hospital Boston and had been diagnosed at least one month earlier. The parents were asked to recall the type and amount of prognostic information they received from their child's physician and the extent to which physician communication made them feel hopeful—rated on a scale of always, often, sometimes, rarely or never. The physicians were also surveyed about the child's prognosis.

The investigators found that sharing more detailed information about a child's prognosis was associated with a greater sense of communication-related hope among the parents of children with cancer: 48 percent of parents reported that physician communication always made them feel more hopeful and an additional 38 percent reported that it often made them feel more hopeful. The poorer the child's prognosis, the less likely the parent was to report communication-related hope, but even for parents of children whose likelihood of being cured was less than 25 percent, there was a positive relationship between receiving more extensive information and feeling hopeful.

The study has several limitations: parents were surveyed up to a year after diagnosis, although researchers did control for the time between diagnosis and when the parent was surveyed; survey respondents represented limited ethnic and cultural diversity; and the authors relied on parents' recall of prognostic disclosure rather than observing conversations directly.

***6510**

Hope and prognostic disclosure

J. W. Mack, E. F. Cook, J. Wolfe, H. E. Grier, P. D. Cleary, J. C. Weeks

Background: Physicians sometimes selectively convey prognostic information to support patients' hopes. However, the relationship between prognostic disclosure and hope is not known. **Methods:** We surveyed 194 parents of children with cancer (overall response rate 70%) in their first year of cancer treatment at the Dana-Farber Cancer Institute and Children's Hospital, Boston, Mass, and the children's physicians. We evaluated relationships between parents' recall of prognostic disclosure by the physician and the extent to which physician communications “always” made them feel hopeful. A five-item index of prognostic disclosure assessed whether prognostic information was provided in any form, in quantitative terms, and in written form, whether the physician gave prognostic information before the parent asked, and whether parents wanted additional prognostic information beyond what they had already received. **Results:** Parents were less likely to report hopeful communication when the child's likelihood of cure was low (OR .70 per category of decreasing likelihood of cure, P=.0003). However, parents who reported having received more extensive prognostic information were more likely to report hopeful communication, even when the prognosis was poor. In a multivariable model, parental report that physician communication “always” made them feel hopeful was associated with increased prognostic disclosure (OR 1.67 per element of disclosure, P=.009) and higher perceived communication quality (OR 5.39, P<.0001). In contrast, communication-related hope was inversely associated with the child's likelihood of cure (OR .67, P=.006). **Conclusions:**

Although physicians sometimes selectively convey prognostic information to preserve hope, we found no evidence that prognostic disclosure makes parents less hopeful. Instead, disclosure of prognosis by the physician can support hope for parents of children with cancer, even when the child's prognosis is poor.

Physician report of likelihood of cure	N	Odds ratio of parent report that communication with the physician "always" made him/her feel hopeful, per element of disclosure (95% CI)	P
>75%	112	1.96 (1.34, 2.86)	.0004
25-74%	57	1.32 (.86, 2.03)	.21
<25%	21	5.98 (1.14, 31.46)	.03

Disclosures for Research Team: Nothing to disclose.

This study is embargoed for release until 7:30 AM CDT, Sunday, June 3.

**CLINICAL SCIENCE SYMPOSIUM
SUNDAY, JUNE 3, 4:30 PM CDT
ROOM E450b**

**Lead Author:
Shaheenah S. Dawood, MD
Presenting Author:
Sharon Giordano, MD, MPH
The University of Texas M. D. Anderson
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Houston, Texas**

Growing Gap Seen in Advanced Breast Cancer Survival Between Black and White Women

An analysis of women with advanced breast cancer over the past two decades has found that disparities in disease-specific survival from breast cancer between black and white patients have increased. While breast cancer-specific survival rates continuously increased for white women, they did not change at all for black women.

“We’ve made huge strides in the treatment of advanced breast cancer, but as a group, black women are not benefiting from these improvements,” said Sharon Giordano, MD, MPH, assistant professor in the department of breast medical oncology at The University of Texas M. D. Anderson Cancer Center in Houston and the study’s senior author. “It is likely that a variety of factors are responsible for this, including access to health care, utilization of screening programs and differences in treatment.”

Using the U.S. National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) program, the researchers identified 15,438 patients who were newly diagnosed with advanced breast cancer between 1988 and 2003. Patients were broken into three groups: those diagnosed from 1988 to 1993, from 1994 to 1998 and from 1999 to 2003. The median age for all patients was 62 years, and median overall survival was 16 months, 18 months and 20 months respectively for the three groups. Median breast cancer-specific survival was 20 months, 21 months and 25 months.

Researchers found that from 1988-1993, the median breast cancer survival was 20 months in whites versus 17 months in blacks; from 1994-1998, it was 22 versus 16 months; and from 1999-2003, 27 versus 17 months. After adjusting for other factors—such as patient age, tumor grade, number of lymph nodes containing cancer cells and estrogen receptor status—the investigators found that race remained a significant factor in survival over time.

Because the information available in the SEER database is limited, the investigators were not able to compare differences in treatment that the patients received. Future research will focus on examining the factors causing racial disparities and ways to eliminate them.

***1000**

Trends in survival of stage IV breast cancer (BC) among Caucasian and African American (AA) BC patients (pts)
S. S. Dawood, K. Broglio, G. Hortobagyi, S. Giordano

Background: The aim of this review was to look at the trends in survival over time in patients(pts) with de novo stage IV BC and to identify factors that impact survival. **Methods:** We searched the SEER registry to identify pts with de novo stage IV breast cancer diagnosed between 1988 and 2003. Pts who were male, did not have microscopic confirmation of disease, had more than one primary, and who had a prior malignancy were excluded. Pts were divided into three groups based on their year of diagnosis separated into 5-year intervals: 1988 - 1993, 1994 - 1998, and 1999 - 2003. Overall survival (OS) and BC specific survival (BCS) were calculated from the date of diagnosis to the date of death, last follow-up, or 12/31/03. Survival outcomes were estimated by the Kaplan-Meier method, and Cox models were fit to determine the characteristics that were independently associated with survival. Follow-up time was censored at 3 years for Cox analyses. **Results:** 15,438 pts were identified. 3796 pts were diagnosed from 1988-1993, 3954 from 1994-1998, and 7688 from 1999-2003. Median age was 62 years. Median follow-up was 16 months (mos) (range 0-191), 18 mos (range 0-199), and 11 mos (range 0-59) in periods 1988 - 1993, 1994 - 1998, and 1999 - 2003 respectively. Median OS was 18 mos overall and 16, 18, and 20 mos respectively for each time period. Median BCS was 23 mos overall and 20, 21, and 25 mos for each time period. In the multivariable model, more distant year of diagnosis, Grade 3 disease, higher number of positive LN, increasing

age, being unmarried, ER- disease, PR- disease, and no surgery were all independently associated with worse BCS. The interaction term between ER and year of diagnosis was of borderline significance, indicating that over time, pts with ER+ disease had decreasing risk of death compared to patients with ER- disease (HR 0.98, 95% CI 0.96-1.00). An interaction term between race and year of diagnosis was significant, such that with each increasing year of diagnosis AA pts had increasing risk of death compared to whites (HR 1.04, 95% CI 1.01-1.07). **Conclusions:** The survival of de novo stage IV BC pts has modestly improved over time. Of concern, survival disparities between AA and white patients increased rather than diminished over time.

Disclosures for Research Team: Nothing to disclose.

This study is embargoed for release until 7:30 AM CDT, Sunday, June 3.

**ORAL PRESENTATION
MONDAY, JUNE 4, 7:30 AM CDT
ROOM S504**

**Lead Author:
Thomas L. Jang, MD
Memorial Sloan-Kettering Cancer Center
New York, N.Y.**

Prostate Cancer Treatment Decisions Influenced by Type of Specialist Consulted

Results of a new study show a strong association between the type of physician seen and the kind of therapy received by men with localized prostate cancer.

“Because no one has definitively shown that one treatment for early prostate cancer is better than another, most patients make treatment decisions based on recommendations of counseling physicians and personal tolerance for the varying side effects,” said Thomas L. Jang, MD, MPH, an instructor in the department of urology at Memorial Sloan-Kettering Cancer Center and the study’s lead author. “Given that, it’s very important for patients to receive an unbiased, balanced perspective on the full range of treatment options.”

Treatment options examined in the study were surgical removal of the prostate (radical prostatectomy), radiation therapy, hormone-reduction therapy and expectant management (also known as watchful waiting), in which the patient’s cancer is closely monitored but he does not undergo any active treatment. Major side effects of prostatectomy are urinary incontinence and impotence. Side effects of radiation therapy include diarrhea and urinary problems. For hormone therapy, side effects include breast tenderness, loss of libido and gastrointestinal problems. Although no medical side effects are associated with expectant management, it can cause worry and anxiety.

Using data from the U.S. National Cancer Institute’s Surveillance, Epidemiology and End Results program, the researchers analyzed the records of 85,088 men with localized prostate cancer who were 65 or older and diagnosed between 1994 and 2002. They found a strong association between physician specialty and the therapy the patients ultimately received. For example, men aged 65 to 69 more frequently had radical prostatectomy when evaluated exclusively by a urologist (70 percent), whereas most men older than 75 chose watchful waiting or hormone therapy if they saw only a urologist (91 percent). In contrast, all men, regardless of age, more frequently received radiation therapy when evaluated by both a urologist and radiation oncologist (78 percent of the younger men and 85 percent of the older men). Differences were also seen if men saw both a urologist and medical oncologist, and if they saw all three specialists (see table below).

Most patients with prostate cancer are seen by urologists first because urologists are generally the physicians who perform biopsies and make diagnoses. “There are currently no established guidelines for what patients should be told by their urologists, but these findings clearly suggest patients should have access to the full range of information before choosing a particular therapy for prostate cancer,” Dr. Jang added.

***6506**

Visits to urologists and radiation oncologists prior to treatment decision making for clinically localized prostate cancer (LCaP)
T. L. Jang, J. E. Bekelman, Y. Liu, P. B. Bach, E. M. Basch, E. B. Elkin, M. J. Zelefsky, P. T. Scardino, C. B. Begg, D. Schrag

Background: The two primary therapies for LCaP are delivered by different types of physicians, urologists and radiation oncologists. We evaluated how visits to various specialists relate to treatment choice. **Methods:** Using data from the Surveillance, Epidemiology and End Results (SEER)-Medicare linked program, we evaluated 85,088 men with LCaP aged 65 and older diagnosed between 1994 and 2002 who received either radical prostatectomy (n=18,201), radiotherapy (n=35,925), primary androgen deprivation therapy (n=14,021), or expectant management (n=16,941) within 9 months of diagnosis. Prostate cancer specialists were identified by Medicare claims or data from the AMA Physician Masterfile. **Results:** Table 1 shows a strong association between the different specialists consulted and primary therapy received. When men aged 65 to 69 saw only a urologist, 70% had a radical prostatectomy; when also seen by a radiation oncologist, 15% had a radical prostatectomy. We

found greater than expected variation in the propensity of a particular urologist's patients to undergo radiotherapy evaluation, suggesting that some men are seen by a radiation oncologist less frequently (and others more frequently) than would be explained by chance. **Conclusions:** Recognizing that prostate cancer specialists have different viewpoints on the most appropriate management strategy, it is imperative to ensure that all men have access to balanced information prior to definitive therapy.

Table 1. Primary therapy according to specialist consulted (N=85,088)							
Specialist		Radical Prostatectomy	Radiation Therapy	Primary Androgen Deprivation Therapy		Expectant Management	
		%	%	%		%	
Urology only (N=42,309)							
	65-69 (N=12,248)	70	5	7		18	
	70-74 (N=10,751)	44	8	17		31	
	75+ (N=19,310)	5	4	45		46	
Urology/Radiation oncology (N=37,540)							
	65-69 (N=10,604)	15	78	3		4	
	70-74 (N=14,058)	7	85	4		4	
	75+ (N=12,878)	2	85	7		6	
Urology/Medical oncology (N=2,329)							
	65-69 (N=601)	53	17	14		16	
	70-74 (N=657)	38	22	17		23	
	75+ (N=1,071)	5	15	46		34	
Urology, Radiation and Medical oncology (N=2,910)							
	65-69 (N=890)	19	70	6		5	
	70-74 (N=1,037)	8	80	7		5	
	75+ (N=983)	2	79	12		7	

Disclosures for Research Team: Nothing to disclose.

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Moderator Dr. Bleyer made the following disclosures: Honoraria from Enzon Pharmaceuticals.

The American Society of Clinical Oncology (ASCO) is the world's leading professional organization representing physicians of all oncology subspecialties who care for people with cancer. ASCO's nearly 25,000 members from the United States and abroad set the standard for patient care and lead the efforts to discover more effective cancer treatments, increase funding for clinical and translational research and ultimately, improve cancer care for the estimated 10 million people diagnosed with cancer worldwide each year. ASCO publishes the *Journal of Clinical Oncology*, the preeminent, peer-reviewed medical journal on clinical cancer research and produces People Living With Cancer (www.plwc.org), a comprehensive consumer Web site providing oncologist-vetted cancer information to help patients and families make informed health care decisions.

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