Conclusion: Lung cancer patients tended to travel farther to be treated with VATS in urban/teaching hospitals with high surgery and surgeon volumes. Other independent determinants of the travel choice included sex, insurance type, and race/ethnicity. Patients' choices and preferences should be taken into account when planning specialized health care delivery services.

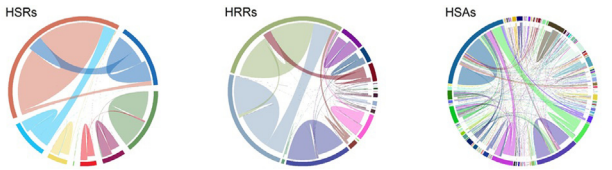


Figure 1. Bilateral flows of lung cancer patients with VATS lobectomy across different health service geographic units in New York State (2007-2012).

Keywords: patient flows, lung cancer, health services, VATS lobectomy

P3.07-016
Ontario's Episode-Based Funding Model Reveals Practice Variation in Adjuvant NSCLC Chemotherapy

Topic: Other — Geographical Differences

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Background: A new episode-based funding model (FM) for ambulatory systemic therapy was implemented in Ontario, Canada in April 2014. The FM bundled reimbursement for components of care, including initial consultation, treatment episodes delivered with adjuvant/curative (AC) or palliative intent and supportive care. Options for evidence-informed AC regimens and their optimal number of treatment cycles and chemotherapy suite visits were informed by the provincial lung Disease Site Group (DSG) based on published literature or group concensus. It was expected that cisplatin-vinorelbine (CISPVINO) would be the most commonly used regimen as CISPVINO was used in the clinical trial conducted in Canada that established CISPVINO as a standard of care and is recommended in Ontario's adjuvant chemotherapy practice guideline.

Methods: The utilization of AC was analyzed for 35 systemic treatment facilities in Ontario comparing actual practice (AP) with "best practice" (BP) (cycle number). For this analysis, cases were included if they started a new course of AC after January 1, 2014 and completed the treatment before July 30, 2015.

Results: The percentage of patients with stage II/IIIa NSCLC receiving AC has been stable at 50-55% for over five years. In this analysis 1,531 cases received some form of AC. 506 cases received chemotherapy with XRT (usually etoposide-cisplatin) and these cases were assumed to be Pancoast tumors or stage IIIa disease on neoadjuvant therapy. The most common regimens prescribed without XRT were cisplatin-vinorelbine (CISPVINO) (331 cases) cisplatin-etoposide (222), carboplatin-etoposide (154) and carboplatin + vinorelbine (74 cases). For all adjuvant chemotherapy excluding XRT (1,025 cases), AP was equal to BP in only 24 % of cases, AP <BP in 73% and AP >BP in 4%. For CISPVINO, AP=BP was achieved in only 36%, AP< BP in 55% and AP > BP in 9%. For the top 5 hospitals by volume administering AC, BP=AP ranged from 8-45%; AP< BP ranged from 41-73%; AP > BP occurred in 20 cases in 3 facilities.

Conclusion: This analysis of first-year funding data provided insights on how adjuvant chemotherapy is administered in Ontario. As expected, CISPVINO was the most commonly used AC regimen (32%) when AC was used alone. However, etoposide-cisplatin was also commonly used alone and in combination with XRT and carboplatin was frequently substituted. BP is only achieved in the minority of cases and there is wide institutional variance. Reasons for this variation need to be better understood and opportunities identified to drive efficiency and standardization.

P3.07-017
Joinpoint Regression Analysis of Lung Cancer Mortality, Turkey

Topic: Other — Geographical Differences

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Background: It is important to investigate the variation of the deaths due to lung cancer in time. The aim of this study is to investigate the variations in the rate of deaths due to lung cancer in Turkey.

Methods: Data on lung cancer mortality during 2009-2014 years were extracted from the Turkish Statistical

Institute and Turkey Public Health Agency mortality data based on Internal Classification of Diseases 10(ICD-10) codes C32-C34. For each gender, age group-specific and standardized rates were calculated by direct standardized method (using the world standard population). These were expressed as rates/100,000 persons. The temporal trend in lung cancer mortality rates were tested for age, gender and methods using Join point Regression Analysis. In join point regression analysis, the best-fitting points where the rate changes significantly (increase or decrease) are chosen. Each join point indicates a statistically significant change in trend, and annual percentage change (APC) is computed for each of trend by means of generalized liner models assuming a Possion distribution.

Results: 119.778 deaths due to lung cancer were recorded; 85.50% (n=102409) of the were in men,14.50% (n=17369)were in women. The mean of crude rate of lung cancer mortality is from 2009 (23.77 deaths/100.000) to 2014 (26.78 deaths/100.000) 26.19 in 100.000, in men 44.00 in women 7.74. The mean of lung cancer age-specific standardized rates from 2009 (49.47 deaths/100.000) to 2014 (54.57 deaths/100.000) is 52.50 in 100.000, in men 45.83 and in women 6.62. Lung cancer mortality rates shows a significant increase between 2009-2014. The rates of lung cancer mortality, between 2009 and 2014 with 4.2% (%95 Confidence Interval: 3.2 to 5.3) showed an important increase annually ($p<0.001$). During working period, throughout men the variation 4.1% (2.8 to 5.5) in the lung cancer mortality rates were significant ($p<0.001$). Similar situation was in women with 5.0% (3.7 to 6.4) ($p<0.001$). The deaths due to lung cancer in young age (under 44 years) in women (5.27%) is more than men (2.59%)($p<0.001$). The decrease of -5.4% (-1.5 to 5.3) in deaths due to lung cancer seen in young men (under 45 years) within years was not significant ($p=0.20$). Similarly in women with same age the variation 3.1% (-2.7 to 9.3 was not significant ($p=0.30$). The variation in men between the ages45-64 deaths due to lung cancer within years 1.5% (-0.3 to 3.4) was not significant ($p=0.10$). Unlike in women in this age group with 3.8% increase (2.2-5.5) showed significance ($p<0.001$). The increase in deaths due to lung cancer seen in men in 65 years of age and over 4.4% (3.6-5.2)was significant ($p<0.001$). With the same result in women 2.6%increase (1.1-4.1) was seen ($p<0.001$).

Conclusion: Even though deaths due to lung cancer show non-significant decrease in male, shows significantly increase above 65 years of age. Increase in lung cancer in young women is remarkable.

Keywords: death rate, lung cancer, sex, age groups

P3.07-018
New European Clinical Trial Regulation: What's Going On?

Topic: Other — Geographical Differences

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Background: In the last decade Europe has faced a sharp slowdown in Clinical Research (CR) mainly due to European Directive 2001/20/CE application. Consequently the European Commission enacted the EU Regulation 536/2014 (ER) that is expected to become effective only in 2018, due to delays in the portal development. To investigate the ER perception and knowledge of the Italian professionals, two online surveys, addressed to Clinical Research Coordinators (CRCs) and Clinical Investigators (CIs), were conducted.

Methods: Two anonymous web-based surveys, both consisting of 17 questions, have been used.

Results: The 62.5% and 58.9% of the contacted CIs and CRCs respectively answered to the survey: 12% of the CIs have a fully knowledge of the incoming ER while many are only partially (64%) or not (24%) informed. 80.4% of CRCs demonstrate a complete knowledge and are already trained. Amongst the evaluated topics, the need of a Reporting Member State in the first stage of the evaluation process is considered as positive by 74% of the CIs and almost all (90%) believe that this procedure will reduce the approval time. With regards to newly imposed transparency standards, 86% of the CIs would welcome the publication of trial results, while 14% believes that this obligation should only apply to profit trials. Overall 70% of CIs state that staff site's facilities already met all of the ER imposed qualification. The 50% of CIs foresee that the ER will promote independent CR while 42% supposes that it will essentially affect the profit trials. Even though 71.4% of CRCs do not have a definite opinion on ER, 85.7% is convinced that it will have a direct impact on their job.

Conclusion: The ER is a turning point for European CR: it is designed to ensure faster procedures, with positive effects both on timing and overall costs and it will require a rigorous methodology and an increased quality. The surveys highlighted different opinions among CIs