ethnic group. **Results:** 25% reported healthy weight (BMI=18.5-24.9); 45% overweight (BMI=25.0-29.9); and 19% and 7% obesity categories I or II+ (BMI=30.0-34.9, 35+). In multivariable analyses controlling for sociodemographics and health care characteristics, we found significant differences in health behaviors and use of preventive services by categories of BMI. Obese men reported lower levels of alcohol consumption and were less likely to be a current smoker. On the other hand, overweight and obese men were less likely to consume a diet with <30% of calories from fat [OR (CI), 0.71 (0.68-0.74); 0.49 (0.46-0.51); 0.38 (0.35-0.41)]. A similar trend was seen for physical activity. Overweight and obese men were less likely to participate in moderate activity [OR (CI), 0.81 (0.78-0.84); 0.51 (0.48-0.53); 0.31 (0.29-0.33)] or vigorous activity [OR (CI), 0.73 (0.70-0.76); 0.47 (0.44-0.50); 0.29 (0.26-0.32)]. An inverse trend was found for sedentary behavior. Men with a BMI of 35+ were twice as likely to report sedentary behavior for 6.5+ hours/day [OR (CI), 2.04 (1.90-2.18)]. For screening exams, overweight and obese men were more likely to report having had their glucose, cholesterol, and triglycerides tested, and among men with diabetes, their HgA1c. In contrast, obese men were less likely to report a PSA test [OR (CI), 0.84 (0.79-0.89); 0.74 (0.68-0.80)] or, among men at average risk for colorectal cancer, a screening sigmoidoscopy [OR (CI), 0.84 (0.79-0.90); 0.73 (0.67-0.81)]. **Conclusions:** Despite having more primary care visits, obese men may be at greater risk due to lower utilization of common screening exams. Results suggest targeted efforts are needed to increase cancer screening and physical activity, and lower consumption of dietary fat among patients with elevated BMIs.

Abstract C-A4-04

One-Year Weight Change and Glycemic Control After Diagnosis of Diabetes Mellitus Type 2

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Background/Aims: Limited real-world data describe weight change, associated factors, and glycemic control after diagnosis of diabetes. This study evaluated weight trajectories, glycemic control, and associated factors in the first year after diagnosis of diabetes mellitus type 2 in otherwise healthy patients. **Methods:** Participants were patients aged 21-75 with diabetes mellitus type 2 diagnosed between January 1, 1997 and December 31, 2004, identified from electronic medical records. Eligible patients for this retrospective cohort study met weight measurement criteria and did not have a condition associated with unintentional weight change (n=4135). We estimated 12-month patient weight trajectories using growth curve analyses, grouped similar trajectories using cluster analysis, and compared characteristics among groups. **Results:** The four weight trajectory groups were 'higher stable weight' (n=757; 18.3%), 'lower stable weight' (n=2236; 54.1%), 'weight gain' (n=664; 16.0%), and 'weight loss' (n=478; 11.6%). Most patients (65.9%) had some weight loss by 8 months and then regained. After adjustments, weight losers were more likely than gainers to be older, be female, take fewer medications, have had nutritionist visits, and have lower mean glycosylated hemoglobin (HbA1c) levels. Weight losers were less likely to be in a race group at higher risk for obesity, have depression or dyslipidemia, or have taken more than 30 days of a sulfonylurea alone or in combination with metformin. **Conclusions:** Most diabetes patients lost some weight after diagnosis. Weight loss trajectories were strongly associated with better glycemic control when compared to weight gain. Patients with certain characteristics may need more support for weight loss, and most need support for weight loss maintenance.

Abstract C-A4-05

US Immigration is Associated With Obesity Among Asian-Pacific Hotel Workers in Hawaii

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Background/Aims: The Work, Weight and Wellness (3W) program is a randomized trial funded by the National Institutes of Health, National Heart, Lung and Blood Institute. The program aims to decrease obesity among hotel workers in Hawaii. In this study we examined patterns of obesity in relation to migration status and ethnicity at baseline. **Methods:** Four thousand five hundred thirty hotel workers in 31 hotels were measured for weight, height and waist circumference at baseline, prior to intervention. Ethnicity and place of birth were self-reported. Data analysis was done using SAS. **Results:** Forty-five percent of hotel workers were born outside of the U.S. Of hotel workers born in the U.S., 35% were born in Hawaii, while 9% were born on the U.S. mainland. Among hotel workers born outside of the U.S., 38% were born in the Philippines, 3% in Japan, 3% in Southeast Asia, 1% in other Pacific islands, and 12% in other locations. Self-reported ethnicity was 44% Filipino, 32% other Asian, 13% Pacific Islander, 9% White and 3% other ethnicity. The body mass index (BMI) of immigrants was 2.2 kg/m² higher than that of non-immigrants, on average, and waist circumference was 5.1 cm higher, on average. The BMI of males was greater than that of females and the interaction of sex and immigration on BMI was significant. The BMI of Pacific Islanders and Filipinos was greater than that of Whites, while BMI of Asians was lower than that of Whites; however, Filipino BMI was no longer greater than White BMI after adjusting for migration status and sex. Being immigrant, male and Pacific Islander was associated with greater BMI, while being Asian was associated with lower BMI. **Conclusions:** Birth outside of the U.S., male sex, Pacific Islander ethnicity and Filipino ethnicity were associated with obesity. Future study will examine the differential effects of the 3W intervention program on obesity, and if this was modified by migration status, sex and ethnicity.

Cancer

Abstract C-B1-02

Spiritual Quality of Life of Long-Term Colorectal Cancer Survivors With Permanent Intestinal Stomas

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Background: Religious and spiritual beliefs can influence adjustment to medical treatments and outcomes. This mixed methods cross-sectional study examined spiritual quality of life (QOL) of long-term colorectal cancer survivors with permanent intestinal ostomies. **Methods:** Men (n=88) and women (n=55) with ostomies whose total scores fell in the upper (n=71) or lower (n=72) quartiles of the validated City of Hope Quality-of-Life ostomy-specific (COHQOL-O) survey provided quantitative and qualitative data regarding spiritual dimensions of QOL. Analyses included chi-square and analysis of variance ± standard deviations with significances set at P<0.05. Content analysis was used to explicate meanings for spirituality items in survey narratives and focus groups. **Results:** The high COHQOL-O group was significantly more likely to be older (74±9 vs. 70±1.3, P<0.01) and married or partnered (72% vs. 55%, P<0.03). Upper quartile subjects had more favorable scores for the spiritual items Sense of Inner Peace, Hopeful, Reason to be Alive, and support from spiritual (e.g., prayer) and religious (e.g., church) activities compared to the lower quartile (all P<0.0001). The two groups did not differ for the item Positive Changes in life related to having an ostomy. Qualitative comments made by participants reflected the meaning of their high or low spiritual QOL scores. **Conclusions:** Spiritual

dimensions of QOL are significantly influenced by an intestinal stoma. Qualitative comments provided insight into the meanings and live experiences related to the spirituality items. Persons with ostomies report less inner peace, feeling less hopeful, not having a reason to be alive, as well as fewer spiritual and religious activities for coping. An understanding of these factors will facilitate integration of holistic care and treatment in this population.

Abstract C-B1-03

The Trustworthiness of Administrative Health Plan Data in Chemotherapy Research

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Background: Collecting chemotherapy administrations is important to any study of cancer treatment. However, abstracting data from medical records can be time consuming while chemotherapy data from tumor registries may be lacking sufficient detail. The goal of this study was to describe the accuracy of automated chemotherapy data from administrative health plan databases compared with data from tumor registries. **Methods:** From eight Cancer Research Network (CRN) tumor registries, we identified 1218 women diagnosed with primary ovarian cancer between January 2004 and June 2006. Using the Virtual Data Warehouse (VDW), we linked cases to all known automated chemotherapy administrations through June 2006 by pooling administrative health plan data from procedure, pharmacy, and diagnosis automated databases. We then calculated the sensitivity of these three data sources for capturing any chemotherapy administrations compared to chemotherapy as coded by tumor registries at each site. **Results:** The health plan data contained records of at least one chemotherapy administration in 51.3% of cases (range across sites 4.3%-80.0%) while the tumor registry data contained such records in 68.8% of cases (range 57.3%-95.2%). The overall sensitivity of administrative data compared to tumor registry data was 69.3% (range 2.9%-95.2%) and varied by administrative data source: 52.8% (range 0.0%-90.3%) using procedures, 46.5% (range 0%-80.7%) using pharmacy records, and 29.1% (range 0.0%-65.9%) using diagnosis codes. Sensitivity decreased over time from 81.4% among cases diagnosed January-June 2004, to 47.7% among diagnoses between January-June 2006. **Conclusions:** Tumor registries appeared to capture the chemotherapy administrations more often than automated health plan administrative data. We noted wide variability in the sensitivity of administrative data by site. Capture of administrative data may be enhanced through site-specific coding of chemotherapy administration and additional understanding at each site of clinical and billing coding practices.

Abstract C-B1-05

Development of an Instrument to Assess Comprehension of Spoken Cancer Prevention Messages

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Background: The ability to understand orally communicated health-related messages is a critical component of health literacy. Recent attention has focused primarily on the prevalence and impact of inadequate health literacy with regard to written communication, largely ignoring that the majority of health information is communicated orally. Most Americans rely on physicians or television for health information, but there is an alarming lack of information on how well people comprehend orally presented health information. We will report on our efforts to develop and validate a computer-based assessment of health literacy—oral around cancer prevention

and screening. **Methods:** Our methods include a multi-step test development process, beginning with iterative team reviews of the dimensions to be considered in test development, a literature review and member interviews to identify potentially confusing terms and concepts, and collection of sample messages from the media and simulated physician-patient encounters to provide a basis for the actual test items. **Results:** Our process identified 13 dimensions to be considered in selecting and scripting the cancer prevention and screening messages that will be included in the assessment. Four of these dimensions are (1) the purpose of the message (instructional, informational/didactic, or query), (2) message style (narrative, statistical, or factual), (3) setting/context (messages available to the public, including those delivered via radio, television, or internet; messages delivered to the individual including messages delivered in physician-patient encounters, or in person or telephone encounters with other healthcare providers), and (4) content (e.g., cancer causes, screening, risk, epidemiology). The presentation will include full descriptions of all 13 dimensions with illustrative examples, the results of the iterative test specification process and sample items. **Conclusions:** We have successfully completed the first steps in developing a test to assess comprehension of health literacy oral in the context of cancer prevention and screening. The next steps include soliciting feedback on our methods and results to date, and suggestions for pilot testing and refining our materials.

Analytic Methods

Abstract C-B3-01

Data Quality Assessment of the Vaccine Safety Datalink Dynamic Data Files

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To enhance our ability to rapidly detect adverse events following immunization, the Vaccine Safety Datalink (VSD) developed dynamic data files (DDF). The DDF are created through weekly extracts of selected electronic medical records data at participating VSD HMOs. However, the timeliness and completeness of these files depend largely on the data storage capacity and infrastructure at each of the HMOs. VSD Data Managers produce a series of weekly, monthly, and annual reports to identify patterns that might signal a data quality problem in the DDF. All sites collect multiple weeks of event data during the weekly data extracts. To assess data quality, we can examine summaries of any particular week of event data repeated over multiple extracts. One data quality report summarizes the number of observations in a dataset for a given event week across multiple extracts, and calculates the percent change in observations across extracts. We used this report to estimate the number of weeks (or 'lag time') until the diagnosis and vaccination data at each HMO become relatively stable in the DDF. For each event week, we estimated the lag time until stability for outpatient diagnoses, inpatient diagnoses, and vaccinations in the DDF. Stability was defined as four consecutive extracts with less than 1% change (positive or negative) from the previous week. We created a set of criteria to define anomalous extract weeks and then imputed the percent change for these anomalous weeks in our estimation of lag time. Anomalous weeks included extracts in which datasets were not updated (i.e., the percent change across event weeks was 0%) and extracts in which the percent change across all event weeks was equal to 5%. The average lag time for outpatient diagnoses ranged from 3 to 19 weeks, and the average lag time for inpatient diagnoses ranged from 3 to 25 weeks across HMOs. The average lag time for vaccinations ranged from 2 to 26 weeks. Our findings suggest that the timeliness of diagnosis and vaccination data varies across the HMOs. In spite of this limitation, the DDF have proven to be a useful tool for rapid vaccine adverse event detection. Continuous data quality assessment of the DDF enables problems to be identified rapidly and either corrected or properly documented.