(10/151), SAs=5.5% (16/292). One-fifth of survivors (SA=22% (65/290), SA=18% (28/154)) reported volunteering on a regular basis an average of 11 (SOs) to 15 (SAs) hours/week. SAs reported more support from employers than SOs (64% (138/215) vs. 53% (60/113), p<.05), and from co-workers (68% (146/214) vs. 57% (64/112), p<.05). SAs and SOs did not differ in marital status at times of diagnosis or survey. The distribution of marital status shifted between diagnosis and survey: 72% (305/425) were married and 10% (43/425) were widowed at diagnosis; 62% (263/424) were married and 20% (84/424) were widowed at time of survey. No differences were reported by treatment about being forced into retirement. **Discussion:** Compared to SOs, SAs were more likely to be currently employed, to receive higher rates of support from employers and coworkers, and to volunteer more hours. Perhaps interventions can be developed to allow ostomy survivors to participate more in these functions in their communities.

**Keywords:** Rectal Cancer; Survivorship; Cancer
doi:10.3121/cmr.2012.1100.ps1-21

PS1-22

**Studying Communication over the Cancer Care Continuum: A Feasibility Study**

Brandi Robinson[1]; Douglas Roblin[1]; Gwen Alexander[2]; Sarah Greene[3]; Cassandra Firneno[4]; Kathleen Mazor[4]

[1]Kaiser Permanente Southeast; [2]Henry Ford Health System; [3]Group Health Cooperative; [4]Fallon Community Health Plan

**Background/Aims:** Effective communication is an essential component of high quality cancer care. Preventing breakdowns and mitigating their harmful effects requires a thorough understanding of the communication process, including the number and types of interactions that a patient experiences over time and the impact of these experiences on the patient. This pilot study investigated the feasibility of "communication logs" to collect primary data on the number, type, mode, and impact of patient-provider communications over the cancer care continuum. **Methods:** English speaking patients, >21 years old, with recent cancer diagnoses were recruited from 4 CRN sites. Clinical staff identified patients meeting eligibility criteria. Patients who agreed to participate were interviewed about their previous communication experiences and asked to maintain a communication log for 4 months, noting all encounters with cancer care providers. Logs could be completed on paper, web-based, or telephone and prompted recording of who was present during the encounter, whether it was in-person, telephone, or email, key content, and global ratings of the communication experience. Participants who logged were asked to complete a post-log interview focused on the experience, timing, and perceived burden of logging. **Results:** Three CRN sites recruited a total of 9 cancer patients. One site was unable to recruit any patients. Four types of cancer were represented (1 thyroid, 1 sarcoma, 1 bladder, 6 breast cancer). Patients' ages ranged from 41 to 69 years. Only 4 patients completed logs; 5 patients reported on their communication experiences in retrospective interviews. Five patients described 10 or more provider encounters in detail. All patients who completed logs chose the web-based option and reported no difficulty submitting logs online. Reports of communication experiences varied ("He [the provider] didn't seem interested. It was like he'd rather be somewhere else." vs. "He [the provider] never made me feel like I was annoying him with my questions."). Main factors contributing to a helpful communication experience included perceived provider sensitivity and sufficient information provided about diagnosis or treatment. **Discussion:** Initial results revealed difficulty recruiting patients early in cancer care. Those who did participate provided valuable information on their experiences, and reported that logging was not burdensome.

**Keywords:** Patient-Provider Communication; Cancer Care; Cancer
doi:10.3121/cmr.2012.1100.ps1-22

PS1-24:

**Validation of AJCC TNM Staging for Breast Tumors Diagnosed Before 2004 in Cancer Registries**

Marilyn Kwan[1]; Reina Haque[2]; Valerie Lee[1]; Joanie Chung[2]; Chantal Avila[2]; Heather Clancy[1]; Virginia Quinn[2]; Lawrence Kushi[1]

[1]Kaiser Permanente Northern California; [2]Kaiser Permanente Southern California

**Background/Aims:** AJCC Tumor (T), Nodal (N) and Metastatic (M) staging is commonly used in clinical practice for treatment decisions. However before 2004, most cancer registries following the North American Association of Central Cancer Registries (NAACR) standards reported only SEER Summary Staging, including the Kaiser Permanente Northern California Cancer Registry (KPNCCR). Information on extent of disease (EOD; extent and size of primary tumor, presence of metastases, lymph node involvement) was recorded as required by NAACR and SEER. The KP Southern California Cancer Registry (KPSCCR) also recorded TNM staging since 1988, in accordance with the American College of Surgeons. We developed an algorithm to map EOD to AJCC TNM stages for female breast cancer cases diagnosed from 1988-2003 identified from the KPNCCR. This algorithm was validated using KPSCCR data from 1996-2003 (n=17,135 cases) with available EOD and TNM information. **Methods:**: The SEER Comparative Staging Guide for Cancer (1993) and the AJCC Cancer Staging Manual 6th edition (2002) were used to derive TNM stages (AJCC Version 6) from KPNCCR EOD variables for breast cancer cases diagnosed from 1988-2003. This algorithm was then applied to KPSCCR EOD variables for breast cancer cases diagnosed from 1996-2003. T, N, M and stage from this algorithm were compared to T, N, M and stage ("gold standard") available in the KPSCCR. Test characteristics (percent agreement, Cohen's kappa, sensitivity, specificity) were calculated. KPNC and KPSC distributions of cancer diagnoses by stage from 1996-2003 were compared. **Results:** Agreement between the derived and available T, N, M variables was excellent (percent agreement and Cohen's kappa): T 93% and 0.91; N 96% and 0.94; M 100% and 0.93. Consistent high sensitivity and specificity were observed except for somewhat lower sensitivity for Stage III (sensitivity, specificity): Stage 0 (0.99, 1.00), Stage I (0.97, 0.98), Stage II (0.91, 0.96), Stage III (0.69, 0.99), Stage IV (0.92, 1.00), Overall (0.92, 0.89). Distributions of derived TNM staging of KPNC and KPSC cases from 1996-2003 were similar. **Discussion:** SEER EOD variables for breast tumors available in SEER-accredited cancer registries can be used to accurately map to AJCC TNM staging for conduct of epidemiologic studies using cancer registry data.

**Keywords:** AJCC Staging; Cancer Registry; Cancer
doi:10.3121/cmr.2012.1100.ps1-24

PS1-25:

**Cervical Cancer Testing and Follow-up in Four Managed Care Plans, 1998-2007**

Sheila Weinmann[1]; Erin Masterson[1]; Heather Gold[2]; Aruna Kamineni[3]; Andrew Williams[4]; Natasha Stout[5]; Azadeh Stark[6]; Terry Field[7]; Kathryn Richert-Boe[1]

[1]Kaiser Permanente Northwest; [2]New York University Cancer Institute; [3]Group Health Cooperative; [4]Kaiser Permanente Hawaii; [5]Harvard Pilgrim Health Care Institute, Harvard Medical School; [6]Geisinger Health System; [7]Fallon Community Health Plan

**Background/Aims:** Cervical cancer screening is performed to detect pre-cancerous cervical intraepithelial neoplasia or invasive cancerous cervical lesions prior to the onset of symptoms so they can be removed before the cancer has developed or spread. With the addition of high-risk human papillomavirus (HPV) testing to the long-established Papanicolaou (Pap) smear, national and health plan screening guidelines have been regularly updated in recent years. Guidelines on screening frequency and follow-up protocols have also changed over time and will likely continue to do so as HPV vaccination becomes more widespread. Here we describe patterns and results of cervical cancer testing and follow-up over a 10-year period within four geographically-dispersed U.S. managed care organizations. **Methods:** Using data collected by the SEARCH: Screening Effectiveness And Research in Community- Based Healthcare project, we analyzed electronic medical