

PS2-29:

Factors Influencing Response to a 2012 FIT Kit Outreach Effort in Kaiser Permanente Northern California

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Background/Aims: To learn about factors that influence decision to take up FIT. **Methods:** Self-administered survey of 3 groups of White, Black, and Latino KPNC members aged 52-75 who were mailed FIT kits in 2010, 2011, and 2012: “Compliers” (CMs) – did FIT all 3 years; “Converts” (CVs) - did FIT in 2012 but not 2010-2011; “Non-Compliers” (NCs) - no FITs 2010-12. **Results:** Preliminary based on 896 respondents (596 CMs, 300 CVs, and 114 NCs). All comparisons reported are statistically significant. 89% CMs, 80% CVs, and 58% NCs: think it’s very important to their KP medical team that they get CRC screening and 91% CMs, 75% CVs, and 51% NCs themselves think it’s very important. This was despite perceived risk of polyps (64%) or CRC (71%) being low. Most frequently indicated reasons for completing FIT (CM+CV) were wanting to make sure I am OK, FIT will help me protect my health, my doctor really wanted me to, FIT more convenient than other CRC screening methods, and spouse/partner wanted me to. Guilt about being sent so many kits was a factor for 43% of CVs. Blacks and Latinos were more likely than Whites to cite pressure from their kids. Almost no one indicated urging from a minister or employer. Many (32% CMs, 50% CVs) used own glove to get their sample. Among NCs, reasons for not doing the FIT were feeling uncomfortable/disgust about the test (e.g., reaching into toilet, handling stool, messiness), concern about mailing the sample, and low CRC risk. CRC “fatalism” was much lower down in the list, with no significant difference by race. 21% of NCs said nothing would make them do the FIT and 17% had no interest in CRC screening. Of those open to CRC screening, 25% want their PCP to tell them why they need it. **Conclusions:** To improve participation in FIT and CRC screening, it may be helpful to involve churches; send multiple kits; have more PCP-patient discussion about CRC screening; and modify FIT kits (e.g., add gloves) to reduce anxiety about exposure to germs and mess.

Keywords: Colorectal cancer screening; Race-ethnic differences
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PS2-32:

Disparities in Oral Capecitabine Use: A Chart Review of Older Patients Treated in the Community

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Background/Aims: Convenient for its oral route of administration, capecitabine is increasingly used in the older population with colorectal and other solid tumors. Since renal impairment increases with age, we designed a pilot study to assess adherence to standard dose reductions for renal insufficiency and dosing recommendations for older patients. We sought to describe patterns of capecitabine use in older patients and factors that influence dosing; specifically age and renal insufficiency. **Methods:** Tumor registries of 8 community-based outpatient cancer clinics were reviewed to identify patients age 65 and older treated for breast, colon, esophageal, pancreas or stomach cancers from 01/01/2001-12/31/2012. Of the 1403 patients identified, 53 received capecitabine. A retrospective electronic medical record review was conducted to collect capecitabine dose and demographic variables, vital signs, adverse events, hospitalizations, and clinical and laboratory data. **Results:** Of the 53 patients who received capecitabine, 21% received a dose appropriate for documented age and renal function. Most patients received doses lower than recommended and, on average, were under-dosed by 25%. Univariate analysis showed women were under-dosed more frequently than men, 85% vs. 55%. Multivariate analysis showed lower than recommended capecitabine dosing for patients with a diagnosis other than colorectal cancer -481 (95%CI -807,-154; $P = 0.01$) and Stage II and III disease -331 (95%CI -646,-16; $P = 0.05$). **Conclusions:** This pilot study suggests that a disparity exists in the dosing of capecitabine in older patients and both men and women received empiric doses of capecitabine below those recommended for renal insufficiency or age. This

may be of particular importance in the adjuvant setting, where under-dosing may compromise outcome. Our findings highlight the need for a more thorough understanding of how chemotherapeutic agents are prescribed for older patients with cancer.

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PS2-33:

Incidence and Treatment of Ductal Carcinoma in Situ in Kaiser Permanente, 2000-2010

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Background/Aims: Ductal carcinoma in situ (DCIS) makes up approximately 25% of all breast cancer diagnoses and is considered to be a precursor to invasive cancer. Most DCIS diagnoses will not progress to invasive cancer, but reliable prognostic and predictive markers to guide treatment have not been established. Considerable debate exists about how to best treat DCIS, and many have expressed concern that DCIS is over-diagnosed and over-treated. This study examined patterns of DCIS incidence and treatment across six regions of Kaiser Permanente (KP). **Methods:** Women aged ≥ 18 years of age diagnosed with DCIS between 2000 and 2010 were identified from tumor registries at each region using distributed code. Annual age-adjusted incidence rates of DCIS were estimated overall and by region and were standardized to the 2000 US population. The annual incidence of DCIS was also estimated for women aged ≥ 45 years and stratified on hormone replacement therapy status at DCIS diagnosis. Demographic characteristics and variation in first course of therapy were compared. **Results:** Across six KP regions, overall age-adjusted incidence was 35.2/100,000 in 2000, increased to a high of 47.2/100,000 in 2007, and then decreased to 42.6/100,000 in 2010. Age-adjusted incidence rates for women on estrogen plus progestin hormone therapy prior to diagnosis were higher than for women on estrogen only or no hormone therapy. The most common first course therapy was breast conserving surgery plus radiation (38%); however, we observed different treatment patterns across regions. These patterns will be explored further in additional analyses that will include examining variation in treatment patterns by age, year of diagnosis, and histopathologic characteristics such as hormone receptor status and tumor grade. **Conclusions:** Although age-adjusted incidence rates from six KP regions were consistent over time, we observed differences in treatment patterns. Differences in patient mix, tumor characteristics, patient, or physician preferences may have contributed to the variation in treatment patterns. These results may be of clinical use in determining factors associated with DCIS diagnosis and in understanding and evaluating regional treatment differences.

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PS2-34:

Disparities in Head and Neck Cancer Patient Survival Relative to Race and Gender

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Background/Aims: Head and neck cancers account for approximately 3% of all cancers in the United States. The majority of these cancer types are squamous cell carcinoma (SCC), but also include salivary malignancies and others. These cancers are nearly twice as common among men as they are among women. Head and neck cancers are also diagnosed more often among people over age 50 years. Over-all disease specific survival rates are around 50%. There have been previous studies that demonstrate racial and gender