of the showing factors loadings higher than 0.6: “conditions related to chemical exposure during pregnancy”, which explained 20% of the variance; “lifestyle exposures”, such as smoking and hair dyes and hair cosmetics use during pregnancy, explaining 17% of the total variance; and “consumption of health services during pregnancy”, such as x-rays and delivery type (cesarean or vaginal delivery), explaining 15% of the total variance. Logistic modelling revealed statistically significant association between childhood leukaemia and chemical exposure during pregnancy (OR=1.16; 95% CI 1.16 to 1.59), and also with consumption of health services during pregnancy (OR=1.27; 95% CI 1.08 to 1.49). The observed results are suggestive of the contribution of environmental exposures to childhood leukaemia development, not just individually, which has been supported by the literature according to carcinogenesis in general, and to leukaemogenesis in particular, as resulting from several mutations triggered by joint environmental exposures.

**P2-84** CHRONIC CONDITIONS AND MAJOR DEPRESSION IN COMMUNITY-DWELLING OLDER ADULTS

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**Objectives** To estimate (1) the prevalence of long-term medical conditions and of comorbid major depression, and (2) the associations between major depression and various chronic medical conditions in a general population of older adults (over 50 years of age) and in persons who are traditionally classified as seniors (65 years and older).

**Methods** Data from the Canadian Community Health Survey-Mental Health and Wellbeing (CCHS-1.2) were analysed. For the purposes of these analyses the dataset was restricted to those aged 50 and over (n=15591). Chronic health conditions were assessed using a self-report method of doctor diagnosis. The World Mental Health-Composite Diagnostic Interview was used to assess major depressive episodes based on DSM-IV criteria.

**Results** The overall prevalence of having at least one chronic condition in those over 50 years of age was 82.4%, compared to 62.0% in those under 50. The prevalence of a major depressive episode in those over 50 with one chronic condition was 3.7%, compared with 1.0% in those without a long-term medical condition. The top 3 chronic health conditions in seniors aged 65 or older were arthritis/rheumatism, high blood pressure and back problems. Chronic Fatigue Syndrome, fibromyalgia and migraine headache had the highest comorbidity with major depression in the senior population.

**Conclusions** Differences were found between rates of chronic conditions and major depression between the general population, older adults and seniors in this study. Primary and secondary prevention efforts should target seniors who exhibit symptoms of depression or highly prevalent chronic health conditions.

**P2-86** EDUCATION AND SURVIVAL OF NON-HODGKIN LYMPHOMA IN DENMARK

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**Introduction** This study examined socio-economic inequalities in survival after non-Hodgkin lymphoma, and to what extent any disparities were explained by differences in comorbidity, disease severity at the time of diagnosis, and the treatment given.

**Methods** Registry-based nationwide cohort study based on 5738 persons diagnosed 2000-2008 from the Danish national lymphoma database and linked for individual socioeconomic information in Statistics Denmark.

**Results** Long-term mortality was highest in patients with a short education as compared to those higher educated. The social difference among patient ≤50 years was increasing over time (Pinteraction=0.01). Thus, in the period 2000–2004 the HR among the short educated compared with the higher educated was 1.47 (95% CI 1.34 to 1.61) and increased to HR=1.70 (95% CI 1.37 to 2.11) in 2005–2008. However, no educational differences were seen among the oldest patients of 81 years and above. The educational gradient was attenuated by including comorbidity in the models, and further slightly attenuated by including lymphoma-specific prognostic factors (stadium, elevated lactate dehydrogenase, extranodal involvement). However, the educational gradient was still significant, as was the interaction with calendar period (Pinteraction=0.03). No socio-economic differences were found with respect to treatment with chemotherapy, radiation, or immunotherapy.

**Conclusion** Differences in survival among NHL patients with different socio-economic position are partly caused by differences in comorbidity and the severity of disease at the time of diagnosis, while no differences in treatment were found. The increasing social gradient over time may be partly explained by a more pronounced decrease in lifestyle-associated comorbidity among higher social groups in recent years.