OBJECTIVES: To assess health care resource utilization and cost of cervical cancer care from the perspective of British Columbia's health care system. METHODS: Retrospective observational data on women diagnosed with cervical cancer between 2004 and 2009 was utilized to calculate patient-level resource utilization from diag-

nosis to death or 5-year discharge. Domains of resource use included hospitaliza-
tion, chemotherapy, radiotherapy, bricklaying or other medically necessary services as laboratory, physician and diagnostics billed under B.C.'s Medical Services Plan and medication dispensed under B.C.'s Pharmcare program. Unit costs were applied to health care expenditures for patients with ovarian cancer. Relevant costs in 2012: CDN dollars, were further separated by chemotherapy protocol, stage at diagnosis, screening history, progression date and age. RESULTS: The average cost of treating cervical cancer in B.C. was $32,023, (95% CI: $29,785 - $34,260). Hospital costs were the largest proportion of cost at a mean proportion of 37.8% (95% CI: 35.3, 39.8) of total cost. Mean length of inpatient hospital visits was 11.2 days, with 2 outpatient hospital visits per patient. Costs were also calculated by relevant clinical subgroups, including progression age, stage, screening history and treatment protocol on cost and resource utilization. CONCLUSIONS: Cervical cancer resource utilization and costs are substantial in B.C.'s health care system. Such data is necessary for decision makers in designing and implementing screening and disease management policy.

PCN71 ECONOMIC BURDEN OF PROLONGED AIR LEAK AFTER LUNG RESECTION: OPEN VERSUS VIDEO-ASSISTED THORACOSCOPIC SURGERY (VATS) Shreya Pillai, John G. Moertel, Bennett R. Cheville, Ashley Marshall MB, BSch, BS, AGCA, FEGELMAN, F Ray 3rd, Ryan M, Gunnarsson, Howington JA 1
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OBJECTIVES: Prolonged air leak (PAL) following lung resection results in increased length of stay (LOS), hospitality costs and mortality. Both open or VATS is preferred for the management of PAL. A systematic review and meta-analysis was performed to analyze the cost-effectiveness of open or by video-assisted thoracic surgery (VATS). This study quantifies the total health care utilization and expenditures in patients who experienced a PAL after undergoing lung resection. METHODS: This study utilized administrative health care claims data from MarketScan® commercial and Medicare databases from 2009-2011. Patients were included if they underwent a lobectomy, segmentectomy or wedge resection. Patients were classified as having a PAL if LOS was greater than 5 days with a similar ICD-9 code 512.1 for prolongation of air leak. Data were analyzed on complication, LOS, readmission, and expenditures. Multivariable logistic regression analysis modeled for the binary outcome of PAL (yes or no). The prevalence of MM (1165 cases) to estimate the treatment burden in Germany for a single AE occurrence. RESULTS: The top 5 AEs across all 3 treatment categories contributing most to the burden were all Gr 3/4 and included neutropenia/leukopenia (mean total cost of €53,871), and immune-related hypophysitis (€23,375). CONCLUSIONS: Substantial costs in the management of AEs are associated with prostate cancer patients. Estimating the treatment burden is critical to planning healthcare resources.

PCN74 ASSESSING THE ECONOMIC BURDEN OF ADVERSE EFFECTS (AEs) ASSOCIATED WITH ANDROGEN SUPPRESSION THERAPY (ASCT) IN PATIENTS WITH METASTATIC MELANOMA (MM) TREATMENTS IN GERMANY Voos K, Amonak M, Bestor U 1
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OBJECTIVES: This study estimated the per-event cost and economic burden associated with ASCT for MM across 3 common treatment categories (chemotherapy [CT], targeted therapy [TT], and immunotherapy [IT]) in Germany as derived from the statutory health insurance (SHI) system perspective. METHODS: A literature review was conducted to evaluate the incidence and types of AEs associated with the 3 treatment categories. A total of 29 AEs (CT: 11; TT: 11; and IT: 7), all-severity grades (Gr) occurring in >20% or Gr 3/4 occurring in >5%, were selected. Medical resource use related to the management of AEs was assessed by conducting 2 blinded Delphi panel cycles with 9 clinicians. Published unit costs were used to estimate the costs per AE and then combined with AE incidence (assuming 1 occurrence/patient/cycle), treatment usage, and 1-year survival rates. RESULTS: Significant direct medical costs (DMC) of €42,737, and indirect non-medical costs (INC) of €110,627, colitis (40,534), diarrhea (37,874), SCC (26,237), and immune-related hypophysitis (23,375). CONCLUSIONS: Substantial costs in the management of AEs are associated with MM patients. Estimating the treatment burden is critical to planning healthcare resources.

PCN75 FREQUENCY AND COSTS ASSOCIATED WITH TARGETED THERAPY-RELATED ADVERSE EVENTS (AEs) DURING FIRST AND SECOND LINE TREATMENT (LOT) AMONG PATIENTS WITH METASTATIC COLORECTAL CANCER (mCRC) Drucker DJ, Benter U, Vauthey J, Flegel M, Moch E, Schuchardt J, Noetzel RA, Bologa CP, Opunt, Edem Prabir, MN, USA, 2Gentech, South San Francisco, CA, USA

OBJECTIVES: To examine AE rates and associated costs among mCRC patients treated with bevacizumab (BV) or cetuximab (CET). METHODS: Using a large national US claims database from 1/2008-3/2012, patients with mCRC were identi-
edified (≥2 claims for colon or rectal cancer and metastatic disease), with enrollment in the health plan for ≥6 months before and after the 1st metastatic cancer claim date. Patients receiving BV or CET during 1st and/or 2nd 12-month period from date of claim were defined as addition of any new agent ≥28d after start of LOT1. AEs identified with ICD-9 codes on health care claims, were assessed from start of 1st targeted therapy (only 5.6% (n=192) received subsequent surgery) and 25.4% (n=866) did not receive either surgery or chemotherapy within 12 months of diagnosis. The mean lifetime costs in patients receiving no cancer directed treatment was $24,467, with the remaining lifetime costs $39,936 for higher and higher incidence of AEs. CONCLUSIONS: The mean lifetime cost in patients receiving nedocromi therapy followed by delayed debulking surgery is double the cost in those receiving FDS. In conjunction with health outcome estimates, findings have important implications for health care resource spending and to assess the cost-effectiveness of deviated first line treat-
mament practices that have emerged in the treatment of advanced ovarian cancer patients.

PCN73 DIRECT MEDICAL COSTS (DMC) OF TREATING PROSTATE CANCER IN A MEDICAL COOPERATIVE HMO IN BRAZIL: RESULTS FROM A LONGITUDINAL ANALYSIS OF AN ADMINISTRATIVE DATABASE Santos MCI, Lúcio CB, Maturana MS

Unimed São José do Rio Preto, São José do Rio Preto, Brazil

OBJECTIVES: The aim of this study is to determine direct medical costs of treating patients with prostate cancer from the perspective of a Brazilian HMO. METHODS: An administrative database containing inpatient and outpatient claims of Unimed São José do Rio Preto, a HMO in São Paulo state with 131,064 beneficiaries, was retrospectively analyzed from Jan/2004 to Dec/2012, with more than 30-days of follow-up data. Diagnosis date for these patients were ascertained and they were followed until death or loss of follow-up. Whatever type of treatment (surgery, or any type of androgen deprivation therapy, chemotherapy, or a combination of these) was provided to the medical claims for each patient included in the analysis. DMC-per-year associated with prostate cancer was calculated and stratified by treatment choice (wait-and-see, local therapy, androgen deprivation, chemotherapy). RESULTS: 312 patients met eligibility criteria, with a median follow-up of 2.94 years. Total DMC in this population was R$ 4,247,664.42, from which R$ 1,675,255.31 (39.4%) are related to diagnostic exams, R$ 792,795.52 (18.7%) to hospitalizations, R$ 615,164.85 (14.5%) to radiotherapy, R$ 333,888.04 (8.2%) to chemotherapy and R$ 831,060.70 (19.6%) to other outpatient costs. A total of 143 patients started treatment as “wait-and-see” with average DMC-per-year related to prostate cancer of R$ 432.64/year, for patients starting local therapy, the average DMC-per-year was of R$ 1,640.95/year; the androgen deprivation group had 19 patients with average DMC-per-year of R $ 850.15/year and 4 patients started chemotherapy with an average DMC-per-year of R$ 938.75/year. CONCLUSIONS: Prolonged survival in patients with prostate cancer represent a significant economic burden to private payers, escalating as disease progresses. Patients starting chemotherapy may cost per year approximately 6 times the cost of patients in early stages of the disease.


A80

In this study, we estimate the lifetime costs of ovarian cancer by primary treat-
ment. METHODS: A cohort of elderly women (≥ 65 years) with stage III and IV ovarian cancer was identified from the Surveillance, Epidemiology and End Results-Medicare linked database from January 1, 2006- December 31, 2009. Cost analysis was conducted from a payer (i.e., Medicare) perspective, and direct medical costs incurred by Medicare were integrated for each patient. Cumulative treatment costs were calculated using phase of care approach (wherein the mean phase specific costs were incurred throughout the survivorship period until death or last follow-up (December 2010). All costs were adjusted for geographic variance and inflation over time and discounted at a rate of 3%. RESULTS: Among 3408 ovarian cancer patients, 32% received FDS to the last targeted therapy (only 5.6% (n=192) received subsequent surgery) and 25.4% (n=866) did not receive either surgery or chemotherapy within 12 months of diagnosis. The mean lifetime costs in patients receiving no cancer directed treatment was $24,467, with the remaining lifetime costs $39,936 for higher and higher incidence of AEs. CONCLUSIONS: The mean lifetime cost in patients receiving nedocromi therapy followed by delayed debulking surgery is double the cost in those receiving FDS. In conjunction with