ing to develop a targeted contrast agent that specifically detects adenomas at increased risk of progressing to CRC. This may further raise the potential of MR colonography. We explored the potential of conventional and targeted MR colonography in terms of (cost-)effectiveness using the ASCCA model.

**Methods:**

Thirteen screening strategies were evaluated, differing in primary screening intervals and in screening rounds. Conventional MR colonography and targeted MR colonography were conventional and targeted MR colonography, colonoscopy and CT colonography with two, three and four screening rounds at a ten year screening interval. Furthermore, eleven rounds of biennial faecal immunochemical test (FIT) screening with two, three and four screening rounds at a ten year screening interval were conventional and targeted MR colonography, colonoscopy and CT colonography. Costs and QALYs were discounted at 3.5% per year.

**Results:**

Incremental costs and effects were estimated from a societal perspective. **Results:** All screening strategies were cost-effective compared to no screening. For conventional MR colonography, the ICER ranged between £1,271 to £3,003/LYG for two to four screening rounds at 34% participation per round. For 62% and 100% participation, the ICER ranged from respectively £1,576/LYG to £3,477/LYG to £3,477/LYG to £6,577/LYG for all participation rates. Targeted MR colonography was more expensive than other screening strategies at comparable LYG, for all participation rates. Targeted MR colonography was only slightly more effective than conventional MR colonography but considerably more costly, even when accounting for costs and effects. These conclusions were consistent across all assumptions regarding test characteristics and costs per test. **Conclusions:** This is the first study to evaluate the cost-effectiveness of MR colonography screening for CRC. Although conventional and targeted MR colonography are cost-effective compared to no screening, at present they cannot compete with more established screening tests because of the high costs per test.

**PCN103**

**COST-EFFECTIVENESS ANALYSIS OF ABIRATONE ACETATE TREATMENT COMPARED WITH CABACATIBEX IN THE REPUBLIC OF PANAMA, IN PATIENTS WITH METASTATIC CASTRATION-RESISTANT PROSTATE CANCER THAT HAVE FAILED HORMONE THERAPY WITH DOXETAXEL**

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**Objectives:** To assess the cost-effectiveness of Abiraterone Acetate plus Prednison (A-P) compared with Cabacabibex in Panamanian patients with Metastatic Castration-Resistant Prostate Cancer (mCRPC) that have failed to chemotherapy with Doxetaxel.

**Methods:** A three-health state cohort Markov Model was developed based on overall and progression free survival data. The time frame was 10 years. The perspective was that of the Public System of Health of Panama.

**Results:** The health outcomes of interest were Quality Adjusted Life Years (QALYs) and Life Years (LYs). Efficacy data was taken from clinical trials (COU-AA-301 for A-P and Tropic for C-P). Utilities for health states and negative utilities for adverse events were estimated based on quality of life endpoints of the COU-AA-301 trial. The base case analysis was determined by using the data from the COU-AA-301 trial. The mean number of QALYs was 0.79 QALYs and 1.35 LYs, respectively. C-P resulted in 0.71 QALYs and 1.28 LYs, per patient, respectively. Mean total costs per patient were estimated to be £11,626 (95% CI: £8,477-14,777) and £8,284 (95% CI: £7,155-9,112) for A-P and C-P, respectively. The incremental cost per QALY gain was estimated to be £3,612 compared to £2,402 for C-P, respectively. The incremental cost per LY gained was estimated to be £8,108 (95% CI: £8,387-11,690) and £7,084 (95% CI: £6,133-11,450) for A-P and C-P, respectively.

**Conclusions:** For Cabacabibex to be cost-effective at a threshold three times the per capita income (£6,000 per QALY) was 82%. The incremental cost per QALY gained was estimated to be £3,612 compared to £2,402 for C-P, respectively. The incremental cost per LY gained was estimated to be £8,108 (95% CI: £8,387-11,690) and £7,084 (95% CI: £6,133-11,450) for A-P and C-P, respectively. The incremental cost per QALY gained was estimated to be £3,612 compared to £2,402 for C-P, respectively. The incremental cost per LY gained was estimated to be £8,108 (95% CI: £8,387-11,690) and £7,084 (95% CI: £6,133-11,450) for A-P and C-P, respectively.

**PCN104**

**EVEROLIMUS PLUS EXEMESTANE COMPARED TO EXEMESTANE AND FU LYNCT TO STRATEGIZE THE TREATMENT OF ER+/HER2- METASTATIC BREAST CANCER IN THE UNITED KINGDOM – A SOCIETAL PERSPECTIVE**

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**Objectives:** This study evaluated the cost-effectiveness of everolimus plus exemestane (EVE+EX) versus exemestane (EX) and fulvestrant (FUL) in the treatment of postmenopausal women with ER+ HER2- metastatic breast cancer in the United Kingdom (UK) from a societal perspective. **Methods:** A partitioned survival model was developed to compare treatment with EVE+EX versus EX and FUL over a 10-year time horizon. Progression-free survival and overall survival for EVE+EX and EXE were estimated from the BOLERO-2 trial. Log-likelihood functions were used to extrapolate trial data beyond the follow-up period. In the absence of head-to-head evidence vs. FUL an indirect treatment comparison was conducted using a Bayesian fixed effect model. Background health state and terminal care resource use were derived from NICE Clinical Guideline 81. Drug costs were taken from the British National Formulary. Productivity loss, defined as working days lost due to disease, was not accounted for. Utility weights. One-way and probabilistic sensitivity analyses were performed. **Results:** The mean number of QALYs was 0.71 (95% CI: 0.66–0.78) and 0.56 (95% CI: 0.52–0.60) for Npg and Gem, respectively, giving an incremental gain of 0.15 (95% CI: 0.08–0.25) QALYs in favour of Npg. The mean cost of therapy per patient was estimated at £11,626 (95% CI: £11,437- £13,027) and £8,284 (95% CI: £7,155-9,112) for A-P and C-P, respectively. The incremental cost per QALY gained was estimated to be £3,612 compared to £2,402 for C-P, respectively. The incremental cost per LY gained was estimated to be £8,108 (95% CI: £8,387-11,690) and £7,084 (95% CI: £6,133-11,450) for A-P and C-P, respectively.

**Conclusions:** For Cabacabibex to be cost-effective at a threshold three times the per capita income (£6,000 per QALY) was 82%. The incremental cost per QALY gained was estimated to be £3,612 compared to £2,402 for C-P, respectively. The incremental cost per LY gained was estimated to be £8,108 (95% CI: £8,387-11,690) and £7,084 (95% CI: £6,133-11,450) for A-P and C-P, respectively.