products in Europe as compared to the US. CONCLUSION: While European regulatory bodies have long-embraced QoL/PROs (along with efficacy and safety) as key endpoints for approval, the FDA is starting to acknowledge pharmacoeconomics in their evaluations. Further research is warranted to determine if there is a correlation between pharmacoeconomic messaging and product uptake, with prescription or unit sales analysis combined with large scale physician surveys on influences of prescribing patterns.

FACTORS ASSOCIATED WITH THE PRESCRIPTION OF ADJUVANT HORMONAL THERAPIES AMONG MEDICAID ENROLLEES WITH BREAST CANCER
McLaughlin J1, Paskett E1, Anderson RT1, Balkrishnan R1
1The Ohio State University College of Medicine, Columbus, OH, USA, 2Wake Forest University School of Medicine, Winston Salem, NC, USA, 3The Ohio State University College of Pharmacy, Columbus, OH, USA

OBJECTIVE: The purpose of this study was to examine various patient and provider characteristics associated with being prescribed an aromatase inhibitors (AI) v. tamoxifen only therapy among a cohort of North Carolina (NC) Medicaid enrollees diagnosed with breast cancer. METHODS: Data was gathered using the linked NC Central Cancer Registry-Medicaid Claims database which links NC cancer registry claims with Medicaid data. A logistic regression model was built to determine the odds of an individual ever receiving an AI during the study period.

RESULTS: A total of 600 patients were included, of which 451 (75.2%) and 149 (24.8%) received tamoxifen only and AI (alone or in combination) therapy, respectively. Results showed that patients who lived in urban areas (compared to rural), were postmenopausal (based on age ≤55), had regional- or distant-staged cancer (opposed to local or unknown), had been hospitalized in the year prior to treatment index, and had breast conserving surgery (BCS) (rather than mastectomy) had a 1.97 [1.29, 3.00], 2.26 [1.80, 2.83], 2.74 [1.79, 4.20], 1.87 [1.20, 2.92], 0.64 [0.41, 1.00] times the odds, respectively, of ever receiving an AI compared to tamoxifen only. Additionally, for every one-year increase in the time a patient started hormonal therapy, the odds of receiving AI therapy (compared to tamoxifen only) increased 2.26 [1.80, 2.83] fold. CONCLUSION: The differences in antiestrogenic treatment type based on whether the patient visited a hospital in the year prior to the study and in whether the patient lived in urban or rural area may represent disparities in access to advances in care. Furthermore, it may be the case that women who undergo mastectomy or who have locally staged cancer are not being treated aggressively enough with novel antiestrogenic therapies.

EFFECT OF THE HUNGARIAN ORGANIZED NATIONALWIDE CERVICAL CANCER SCREENING PROGRAMME ON THE COVERAGE OF WOMEN UNDER THE AGE OF 25 YEARS
Boncz l1, Bôdös J1, Sebestyén A2, Betelehem J1, Galusci L3, Ágoston I1, Nagy Z4, Kriszbaché l1
1University of Pécs, Pécs, Hungary, 2National Health Insurance Fund Administration, Budapest, Hungary, 3Corvinus University of Budapest, Budapest, Hungary, 4Health Insurance Supervisory Authority, Budapest, Hungary

OBJECTIVE: Organized nationwide screening programme for cervical cancer was introduced in Hungary in 2003. The aim of this study is to analyze the three year screening rate (coverage) of the organized cervical cancer screening programme in women aged less than 25 years. Although women under 25 years are out of the scope of the organized screening programme, opportunistic screening may be applied.

METHODS: The data derive from the financial database of the National Health Insurance Fund Administration (OEI) of Hungary covering the period of 2000–2002 (without organized screening) and 2003–2005 (with organized screening). We calculated the three-year screening rate for 2003–2005 according to the age-group of women less than 25 years (15–19 and 20–24). Screening is defined with cytological examination of Papanicolau smear and includes all smears taken either within or outside of the organized programme. RESULTS: The three-year screening rate of women aged 25–64 years was 52.65 % in 2003–2005. The coverage of women under 25 years was the following in 2003–2005: 15–19 years: 31.94 %; 20–24 years: 61.20 %. Comparing this values to the coverage of 2000–2002 (without organized screening) we found a decreasing tendency in these two age-groups: 15–19 years: −0.06 percent point decrease (non-significant), 20–24 years: −6.28 percent point decrease (p < 0.01). CONCLUSION: We found that coverage of women aged 20–24 being out of the scope of the organized cervical cancer screening programme is higher (61.2 %) than the average of target age group of 25–64 years (52.65). Despite of this finding, the coverage of women 15–19 and 20–24