based on a randomized trial directly comparing bicalutamid and flutamide. Costs and quality of life effects related to therapy were based on published sources. Cost-effectiveness was calculated for 60 and 120 months from start of therapy. RESULTS: The incremental cost per quality adjusted life year (QALY) gained for bicalutamid vs. flutamide was $22,000 and $16,000 per QALY at five and ten years, respectively. If quality adjustment was not included, the incremental cost-effectiveness ratio (ICER) for CAB with bicalutamide over CAB with flutamide was even more favorable ($20,000/QALY gained at five years). These ICER estimates are well within the commonly accepted cost-effectiveness threshold. One way sensitivity analysis demonstrated that the cost-effectiveness estimates were most sensitive to drug costs and survival (baseline survival was not significantly different between therapies). Multi-way uncertainty analysis revealed that the median value of the ICER at five years was $13,637/QALY when all the parameters were varied over a clinically reasonable range. CONCLUSIONS: Bicalutamid is cost-effective compared with flutamide when used for androgen blockade as part of combined androgen blockade for men with advanced prostate cancer.

**RESOURCE UTILIZATION AMONG PROSTATE CANCER PATIENTS WITH BONE PAIN**

**Kurth H,1 McKiernan J,2 Thomas SK,2 Bentkover JD1**

1Innovative Health Solutions, Brookline, MA, USA; 2Columbia Presbyterian, New York, NY, USA

**OBJECTIVES:** Bone metastases occur in up to 80% of advanced prostate cancer patients, and could result in painful and debilitating skeletal complications. The objective of this study was to evaluate resource utilization in advanced prostate cancer patients with versus without bone pain. **METHODS:** A multi-center retrospective chart review combined with prospective quality of life and pain assessment study was initiated to collect data from approximately 375 patients from 73 US community urology practices. Patients were categorized as either with or without bone pain. Interim analysis compared resource utilization (hospitalizations, physicians visits) between the two groups, using t-tests and Chi-square tests (p < 0.05) to assess differences. **RESULTS:** Of 277 patients recruited to date, mean age was 76 years, and majority (74%) were Caucasian. About 39% (N = 109) had bone pain and the remaining 61% did not. Patients with bone pain were significantly younger than those without (75 vs. 77 years) and more likely to have bone metastases (62% vs. 40%). However, the groups did not differ significantly in ethnicity, education, or comorbid conditions. Patients with bone pain were over twice as likely to have been hospitalized in the past year (28% vs. 13%) than those without and averaged 1.3 hospitalizations per patient and 4.2 days per stay. While outpatient visit rates were similar, patients with bone pain were less likely to make routine physician visits (42% versus 61%), instead seeking treatment for non-routine reasons (e.g. LH-RH agonist administration, initial/post-op consults, procedures/surgery). Patients with bone pain were more likely to visit for SRE (8% vs. 3%) and to receive a referral to oncology/urology (6% vs. 3%) at physician visits. **CONCLUSIONS:** Patients with bone pain have increased health resource consumption, particularly hospitalizations, than patients without bone pain, which may result in substantial economic burden.
breast cancer risk, while 11.6% and 14.3% of respondents believed that they were at higher, 5-year and lifetime risk of breast cancer as compared to an average woman, respectively. A low but significant correlation (0.167, p = 0.045) was found between respondents’ actual risk and perceived risk of breast cancer. A large proportion of women (42.6%) were not sure whether or not they would consume chemopreventive tamoxifen for breast cancer if advised by their doctor. Only 16.7% women expressed willingness to consume tamoxifen. No relationship was found between women’s perceived and actual risk of breast cancer and their mammography screening behavior or willingness to consume chemopreventive tamoxifen. CONCLUSIONS: Actual and perceived risk of breast cancer does not seem to be associated with their screening behavior or willingness to consume chemopreventive tamoxifen in this population. Relatively few women in this population may opt to consume chemopreventive tamoxifen for reducing their risk of breast cancer.

PCN18

OPIOID USE IN A LARGE NATIONAL HOSPICE POPULATION: EXAMINATION OF CANCER VERSUS NON-CANCER PATIENTS
Weston C1, Poston S1, Pizzi L1, Goldfarb N1, Sikirica V2, Reisfsnyder J2, Maxwell TL3
1Jefferson Medical College, Philadelphia, PA, USA; 2Janssen Medical Affairs, LLC, Titusville, NJ, USA; 3ExcellerRx, Inc, Philadelphia, PA, USA

OBJECTIVES: To investigate opioid use in a large sample of hospice patients and examine differences in opioid use between cancer and non-cancer patients. METHODS: This project was conducted with excellerRx, a large hospice pharmacy provider which contracts with 15% of hospices throughout the US. Patients included were age 65 or older admitted to hospice between June 1, 2003 and December 31, 2003. Pharmacy data through June 30, 2004 was analyzed. Average daily opioid equivalent (ADOE) use was calculated for each patient by converting total opioid dispensed to morphine equivalents. Associations between demographic variables and clinical characteristics with opioid use were examined. Analysis of variance (ANOVA) was conducted to examine differences in opioid use between cancer and non-cancer patients. RESULTS: The sample consisted of 43,537 patients representing 4 diagnostic categories: cancer (46%); heart diagnoses (13%); lung diagnoses excluding lung cancer (7%); and other (33%). Half (n = 21,767 patients) were dispensed 1 or more opioids during their hospice stay. For these patients, the ADOE ranged from 0.03 to 15,305 (mean = 47.0; SD = 140.0). There was a significant inverse correlation (p < 0.0001) between opioid use and age, and male patients were dispensed more opioids (mean = 50.2 ADOE) than females (mean = 44.1 ADOE, p < 0.05). There were no differences in opioid use by race, hospice region, or hospice size. ANOVA testing revealed that opioid use among patients with a hospice diagnosis of cancer differed from those without cancer (ADOE = 54.3 cancer vs. 35.0 non-cancer; p < 0.0001), and mean length of hospice care was shorter for cancer vs. non-cancer patients (43.4 days and 55.2 days, respectively; p < 0.0001). CONCLUSIONS: Few studies have investigated opioid use in a national hospice population, in particular, the differences between cancer and non-cancer patients. Significant differences in opioid use were noted, suggesting the need for further research on how to best deliver hospice services for this fragile population.

PCN19

VARIATIONS IN INPATIENT PROSTATE CANCER TREATMENT IN FLORIDA
Campbell ES, Grant S
Florida A&M University, Tallahassee, FL, USA

Prostate cancer is the most common cancer affecting American men and the second leading cause of cancer deaths in the US. African-American men have the highest prostate cancer incidence and mortality rates in the world. OBJECTIVE: The purpose was to investigate differences across racial groups in the disease state and treatment of men hospitalized for prostate cancer. METHODS: Data Source—Florida Agency for Health Care Administration (AHCA) hospital discharge data for 2002. Each record represents a patient discharge and includes patient demographics, diagnoses, procedures and charges for the stay. Study population includes all patients under 80 years old with a primary diagnosis of prostate cancer hospitalized in Florida during 2002. Analysis: SPSS was used to compare procedures, co-morbidities, and patient outcomes of discharge status, length-of-stay and total charges. Chi-Square tests and ANOVA were used to detect significant differences across racial groups. RESULTS: A total of 5444 men were included in the analysis. The average age was 64.5 years, with 73% of the patients Caucasian, 12% African-American, 11% Hispanic and 4% other races. Average length of stay was 3.3 days, costing about $23,000 per stay. Medicare was the primary payer for over 47% of the hospitalizations. Prostatectomy was performed on 81.5% of the patients with no significant differences across racial groups. Hypertension was reported in 41.5% of the patients, occurring significantly more in African American patients. On average, African Americans had significantly higher hospital charges and length of stay, yet were significantly younger than Caucasians. Finally, African Americans were more likely to have a discharge status of death than any other racial group. CONCLUSIONS: African American men hospitalized for prostate cancer have very different experiences than men of other racial groups. Further research is necessary to determine why this disparity occurs and how it might be attenuated.

PCN20

A SYSTEMATIC REVIEW OF PHYSICIAN KNOWLEDGE AND PRACTICE PATTERNS REGARDING COLORECTAL CANCER SCREENING
Khanna R, Kavookjian J
West Virginia University, Morgantown, WV, USA

OBJECTIVE: Colorectal Cancer (CRC), when detected early, can be treated, reducing morbidity and mortality. In 1997, the American Cancer Society issued major revisions for CRC screening guidelines to include new research findings and improvements in testing accuracy. Research suggests that physicians do not always follow CRC screening guidelines; lack of knowledge about appropriate guidelines or guideline changes is often cited as a barrier. The aim of this systematic review was to examine studies measuring physician CRC screening knowledge and related practice patterns. METHODS: A tiered systematic search (1997–2004) was conducted for studies, irrespective of design, which were published in peer-reviewed journals through MEDLINE, Academic Search Elite, CancerLit, CINAHL, and PsycINFO databases. Tier 1 search combined keywords “knowledge” and “physicians” with “colorectal cancer screening” which identified 48 studies. Tier 2 search combined keywords “practice patterns” and “physicians” with “colorectal cancer screening” which identified 52 studies. Tier 3 was a review of papers identified in Tiers 1 and 2. Ten studies meeting the “knowledge” and “practice patterns” inclusion criteria were retained. RESULTS: Studies reported that a significant percentage of physicians were performing Fecal Occult Blood Test on stool samples obtained from Digital Rectal Examination, a method that often produces false results. Roughly half of physicians were reported to be performing screening tests without