pleted the EQ-5D-5L. Inclusion criteria were current chronic phase of CML visits after June 2006; 12 years of age or older; and no concomitant or recent malignancy. Eligibility was determined following confirmation of the sample population and derivation of a utility value for each patient. Kruskal Wallis test was conducted to compare the utility values for non-parametric data, and t test was conducted for parametric data. A utility value of 0 implies death, while a value of 1 implies full health. **RESULTS:** Of the 81 questionnaires that were mailed, 33 (40.7%) were returned. Three returned questionnaires were excluded due to failure to complete the instrument, and one patient passed away. Of the 29 patients in the final analysis, 5.4% were male, the mean age at diagnosis was 70.9 ± 15.25 and the mean duration of CML was 5.1 ± 3.6 years. For current CML treatments, 3 patients had undergone stem cell transplantation (SCT), 25 patients were receiving tyrosine kinase inhibitors (TKIs), and one patient discontinued medication due to severe adverse events. Overall, the mean utility difference between the SCT and TKIs was not statistically significant (0.72 ± 0.15 vs. 0.80 ± 0.15, p = 0.35). Among TKIs, nilotinib had the highest utility scores (0.88 ± 0.14, n = 10), followed by ponatinib (0.83 ± 0.15, n = 3), nilotinib (0.82 ± 0.13, n = 6), dasatinib (0.72 ± 0.14, n = 10) and IM (0.64 ± 0.15, n = 8). There was no statistical difference in utilities in patients who received one line of treatment (0.83 ± 0.15, n = 13) vs. multiple lines (0.76 ± 0.15, n = 12, p = 0.22). **CONCLUSIONS:** Although the study population was small, our results indicate that current US CML patients have good Qol scores. A larger sample size is needed for further research.

PCN143

SANDOSTATIN LAR LAB PATIENT JOURNEY

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**OBJECTIVES:** Carcinoid tumors are a type of neuroendocrine tumor (NET), most often occurring in the gastrointestinal tract. These tumors are rare and difficult to identify, since symptoms are often associated with other conditions. Once correctly identified, 25-50% of symptomatic patients are diagnosed with Sanchez et al's. In this study we sought to identify the typical NET patient journey, from onset of symptoms to diagnosis and treatment. **METHODS:** 75 NET patients that are currently treated with Sandostatin LAR were interviewed by telephone using a 30-minute structured questionnaire comprised of a mix of closed-ended and open-ended questions. **RESULTS:** More than three quarters (76%, n = 29) of patients saw 2 or more physicians before NET was diagnosed. Two-fifths (43%, n = 32) of respondents were misdiagnosed prior to receiving NET diagnosis, with 53% (n = 17) of misdiagnoses existing for more than 1 year. In 29% of patients, the correct diagnosis and appropriate treatment of NET was delayed for more than 1 year. **CONCLUSIONS:** These findings indicate that Canadian patients can experience significant delays in the correct diagnosis and appropriate treatment of NET. This is attributable in part to the non-specific nature of the signs and symptoms of NET, but also due to a lack of awareness of NET among frontline physicians and the general public.

PCN144

RELATIVE INFLUENCE OF FACTORS DETERMINING A WOMAN'S PREFERENCE FOR TREATMENT OPTIONS IN OVARIAN CANCER: A DISCRETE CHOICE EXPERIMENT

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**OBJECTIVES:** To examine relative preferences for symptoms, treatment-related side-effects and progression-free survival (PFS) in women with ovarian cancer using a discrete choice experiment (DCE). **METHODS:** A pilot study was conducted of women with advanced or recurrent ovarian cancer. In the DCE, participants were asked to choose between two treatment scenarios, modeled on characteristics of standard intravenous (IV) and intraperitoneal/intravenous (IP/Iv) treatments for newly diagnosed ovarian cancer. Each scenario included 7 attributes with 2-3 levels each: mode of administration (IV versus IP/Iv), visit frequency (one per week, two per week, three per week, or three per week); treatment-related abdominal symptoms, neuropathy, fatigue, nausea, and vomiting; and PFS (15, 18, 21 and 24 months). We used a balanced overlap design with 10 versions of the survey. Each participant evaluated 12 random choice and one fixed-choice scenario. Mixed logit regression modeled participant’s choices as a function of attribute levels. **RESULTS:** 95 women completed the survey. Mean age was 57 and 81% were Caucasian. Half (47%) had experienced going treatment for another condition, while in 33% cases (6/18*100%; n = 29), patients were receiving tyrosine kinase inhibitors (TKIs), and one patient discontinued medication due to severe adverse events. Overall, the mean utility difference between the SCT and TKIs was not statistically significant (0.72 ± 0.15 vs. 0.80 ± 0.15, p = 0.35). Among TKIs, nilotinib had the highest utility scores (0.88 ± 0.14, n = 10), followed by ponatinib (0.83 ± 0.15, n = 3), nilotinib (0.82 ± 0.13, n = 6), dasatinib (0.72 ± 0.14, n = 10) and IM (0.64 ± 0.15, n = 8). There was no statistical difference in utilities in patients who received one line of treatment (0.83 ± 0.15, n = 13) vs. multiple lines (0.76 ± 0.15, n = 12, p = 0.22). **CONCLUSIONS:** Although the study population was small, our results indicate that current US CML patients have good Qol scores. A larger sample size is needed for further research.

PCN145

PHYSICIANS' PREFERENCES FOR BONE METASTASES TREATMENTS IN CANADA

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**OBJECTIVES:** Among the bone-targeted agents (BTAs) currently approved for the prevention of bone metastases in patients with solid tumors, several different drugs are available. Most of these BTAs are administered by physicians when making treatment decisions. This study evaluated Canadian physicians’ treatment preferences for BTAs used to prevent SREs in patients with bone metastases from solid tumors. **METHODS:** Physicians treating patients with bone metastases and who treated at least 2 patients with a BTA were invited to participate in the study and complete an online survey. The survey was on average 1 page long and consisted of a series of questions designed to capture physician decisions on the basis of treatment selection. Physicians were asked to indicate their treatment preferences (primary or secondary) for 12 different scenarios representing various scenarios. The analysis included descriptive statistics, including comparisons of preferences among scenarios, and included a chi-square test for the comparison of preferences between groups. **RESULTS:** A total of 200 Canadian physicians completed the survey. Over the attribute levels included, months until first SRE, the risk of renal impairment, and months until worsening of pain (3, 6, and 10 months) were the most important attributes for physicians, with high scores for these attributes significantly preferred over levels (p < 0.05). For mode of administration, subcutaneous injection was preferred over infusion regardless of duration (p < 0.05). **CONCLUSIONS:** When making treatment decisions regarding choice of BTA for patients with bone metastases, delaying the onset of SREs and managing the risk of renal impairment are the primary considerations for Canadian physicians. Also, respondents had well-defined preferences for subcutaneous injections over infusion every 4 weeks.

PCN147

RECRUITING AND INTERVIEWING NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER PATIENTS FOR QUALITATIVE STUDY PARTICIPATION VIA AN INTERNET-BASED DIGITAL PATIENT COMMUNITY

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**OBJECTIVES:** To perform a qualitative patient interview study using an internet-based digital platform for recruitment and telephone and webinar for interviews. **METHODS:** To design the qualitative study we followed the steps outlined in the ISPOR PRO Good Research Practices Task Force Report: Part 1 (Patrick et al, 2011). Briefly, a qualitative interview guide was developed and approved by IRB. Participants were recruited, consented, enrolled, and interviewed online. Each interview was audio recorded and transcribed. Analysis of the qualitative data was performed by experienced market researchers. **RESULTS:** Screening, demographic, and disease characteristics data was collected directly from patients online, via the Internet, with no interaction from the patient's physician(s) or site. Existing members of MedGuard, an online free medication monitoring service, were sent an email inviting to participate in the study. Participants who chose to participate were directed to a website where they accessed information regarding the study, provided consent to participate, self-screened for eligibility, and reported baseline characteristics. Consented participants were contacted via phone to schedule a time to participate. Individually scheduled telephone or webinar interviews were audio recorded, and lasted 60-75 minutes. 17 patients were interviewed. **CONCLUSIONS:** Recruiting and interviewing patients via the internet and phone is a feasible, faster, and potentially lower cost alternative to face-to-face interviews. Some benefits of direct to patient research include potential to reduce patient travel burden to a study center and potentially lower cost alternative to face to face interviews. Some benefits of direct to patient research include potential to reduce patient travel burden.