$141,220/QALY versus orchiectomy. Changes in key variables in the sensitivity analyses did not affect the ranking of the treatment strategies, suggesting that the model was robust.

**CONCLUSIONS:** LAs were dominated by orchiectomy in the base case analysis and most sensitivity analyses. Combination therapy displayed incremental cost effectiveness ratios over orchiectomy ranging from approximately $30,000 to over $100,000 per QALY. Orchiectomy was more effective, had fewer severe adverse reactions, and cost slightly more than DES, the least expensive treatment. However, due to potential psychological impact, further research is warranted to examine its acceptance by patients. Despite robustness, the utilities used in the model warrant further research.

**CONCLUSION:** Men at-risk for PC had utilities values for health states associated with treatment options intermediate between healthy men and men with cancer, supporting our hypothesis. We discuss why populations at-risk may theoretically be more congruent with Welfare Economics and the Veil of Ignorance concept than populations previously reported in the literature.

**COMPARISON OF TREATMENT MODALITIES IN PROSTATE CANCER PATIENTS**

**OBJECTIVE:** To determine if cancer treatment choices differ for prostate cancer patients who have had other prior cancers versus those with no history of cancer.

**METHODS:** Study was conducted using IMS HEALTH’s LifeLink database, a U.S. employer claims database consisting of more than 1.8 million covered lives, with linked medical and pharmacy claims for employees, dependents, and retirees from 1991 forward. Patients selected for the study were newly diagnosed with primary prostate cancer between 1996–1997 and had at least one claim for a therapy of interest (drug, surgery, or radiation) following their cancer diagnosis. Differentiation of prostate cancer patients with prior cancers and those without was based on the documentation of any cancer diagnoses in the 36 months preceding their initial prostate cancer diagnosis. Patients were observed for 36 months after their diagnosis.

**RESULTS:** 5,569 patients met the inclusion criteria of which 2,811 had a history of prior cancer diagnoses, and 2,758 had no history of prior cancers. Prostate cancer patients with prior cancers were significantly more likely to receive chemotherapy than patients without prior cancers (p = 0.015) but were less likely to receive surgery than patients without prior cancers (p = 0.011). Among patients treated with chemotherapy, those with prior cancers were more likely to receive fluorouracil (p = 0.001), whereas patients with no prior cancers were more likely to receive methotrexate (p = 0.002). Initial treatment modalities also differed significantly (p < 0.001), with prior cancer patients more likely to initially receive chemotherapy than patients without prior cancers (p < 0.001) and significant differences in initial hormonal therapies prescribed (p = 0.024). Among patients with initial hormone therapy, those with prior cancers were more likely to initially receive dexamethasone (p < 0.001).

**CONCLUSIONS:** Treatment of prostate cancer differs based on patient’s history of other cancers, both in type of treatment received (drug, surgery, or radiation) and selection of hormonal and chemotherapy regimens.