move, but some had ascites, pleural effusion, jaundice, dyspnea (3-10%), and used chemotherapy did not show a significant change in QOL-scores. LCPs receiving 1st and 8.3% with other types of lung cancer. Symptom trajectories during adjuvant treatment, but also to palliate symptoms and maintain or even improve their health status adjustments in cost-utility analyses used in future HTA’s.

PCN117 QUALITY OF LIFE IN PATIENTS WITH MALIGNANT ASCITES AFTER TREATMENT WITH CATUMAXOMAB: A MULTICENTER PHASE II/III STUDY COMPARING PARACENTESIS PLUS CATUMAXOMAB WITH PARACENTESIS ALONE

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OBJECTIVES: Malignant ascites (MA) is associated with poor prognoses and limited palliative therapeutic options. Therefore, a change in patients’ health-related quality of life (HRQoL) is of particular importance to demonstrate added value of a new treatment over the patient-reported outcomes (PRO). Moreover how fast the change occurs can be as important as the simple occurrence of a meaningful change in HRQoL. Following demonstration of superiority on puncture-free survival of catumaxomab plus paracentesis vs paracentesis alone, this study aimed to compare time to deterioration in HRQoL between both treatment groups by using survival analysis techniques. METHODS: In a randomized, multi-center, phase II/II study in patients with MA, HRQoL was measured by using the European Organization for Quality of Life (EQ-5D) for metastatic castration-resistant prostate cancer (mCRPC) patients using FACT-P (Functional Assessment of Cancer Therapy-Prostate). METHODS: Observational study conducted in 47 centres across 6 countries (Belgium, France, Germany, Sweden, The Netherlands, UK) collected HRQoL data for 698 patients with confirmed mCRPC and documented disease progression. Utility values were derived from EQ-SD profiles based on a UK-specific EQ-SD value set (5). Predictive validity of the 5 FACT-P subscales, patient demographics, co-morbidities and prior chemotherapy for utility values was tested using ordinary least square (OLS) model, Gamma and Tobit multivariate regression models. RESULTS: At the time of assessment, mean age was 71.4 years (SD 9.6) and 33% of patients were treated with chemotherapy, 24% had prior chemotherapy, and 43% were chemotherapy naïve. At diagnosis, 35.9% of patients had metastases and 84.1% had Gleason ≥ 7. Mean FACT-P and EQ-5D-5L utility were 104.0 and 0.67 respectively. QoL scores were derived from EQ-SD profiles based on a UK-specific EQ-SD value set (5). Predictive validity of the 5 FACT-P subscales, patient demographics, co-morbidities and prior chemotherapy for utility values was tested using ordinary least square (OLS) model, Gamma and Tobit multivariate regression models. CONCLUSIONS: The developed algorithms enable translation of cancer-specific health-related quality of life measures to preference-adjusted health status in mCRPC patients. Findings will help to develop health status adjustments in cost-utility analyses used in future HTA’s.

A430

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PCN116 MAPPING FACT-P TO EQ-SD IN A LARGE CROSS-SECTIONAL STUDY OF METASTATIC CAstration-RESISTANT PROSTATE CANCER PATIENTS

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OBJECTIVES: To construct and validate a prediction model of preference-adjusted health status (EQ-5D) for metastatic castration-resistant prostate cancer (mCRPC) patients using FACT-P (Functional Assessment of Cancer Therapy-Prostate). METHODS: The FACT-P mapping approach, 10 oncology medications with PRO labels came from two sources: 1) a case-control study with 120 patients with metastatic castration-resistant prostate cancer (mCRPC) treated with chemotherapy and 2) a systematic review of 10 PRO-based label claims in oncology. RESULTS: The FACT-P mapping approach was validated using 2277 patients with mCRPC treated with chemotherapy. The FACT-P mapping approach was validated using 2277 patients with mCRPC treated with chemotherapy. CONCLUSIONS: Though aggressive, adjuvant treatment did not endanger patients’ QOL. 1st line palliative chemotherapy proved to be helpful in maintaining and stabilizing patients’ QOL, since deteriorations have been limited.