rospective study was based on the National Health Insurance Fund Administration financing database. The study period spanned between 01.01.2005 and 12.31.2014. Several oncological fields were investigated: lung cancer (ICD C34), prostate cancer (ICD C61), kidney cancer (BNO C64-C65), breast cancer (ICD C50), haematopoietic and lymphatic system cancer (ICD C81-85, C88, C90-96) and colorectal cancer (ICD C18-C20). The trends in overall survival (OS) have been computed and compared for each subgroups using Cox proportional hazard models. **RESULTS:** In general there was found that age, metastatic stage and comorbidities were the most relevant covariates in all groups. Analysing trends of mortality there is a difference between patients who were diagnosed in 2007 comparing to those who were diagnosed in 2011. **CONCLUSIONS:** The magnitude of the fitted trends could be very different, the precise reasons of the differences and the difference of cost, the relative risk of the mortality, and the comorbidity effects within the variant disease groups should be further investigated. The applied framework methods can serve both direct comparison and forecasting models in care management, e.g. Disability-Adjusted Life Year, Quality-Adjusted Life Years, Years of Potential Life Lost.

PCN10

PREVALENCE OF DEPRESSION AND ANXIETY AND THEIR RISK FACTORS IN WOMEN WITH BREAST CANCER IN GERMAN PRIMARY CARE

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OBJECTIVES: Although the psychological effect of breast cancer (BC) diagnosis is well documented, less is known about the prevalence of, and risk factors for depression and anxiety in the BC patients. **METHODS:** Women initially diagnosed with breast cancer (ICD 10: C50) between January 2009 and December 2013 (indexdate) were identified from 1,202 general practitioner's (GP) and 244 gynecologist's (GYN) practices in the IMS Disease Analyzer database. Patients were included only if they did not have any diagnosis of depression or anxiety within 12 months before index date.. The main outcome measure was the first diagnosis of either depression or anxiety disease within one year after indexdate. A total of 23,709 patients at GPs and 19,977 at GYN were available for the analysis. **RESULTS:** Baseline characteristics of study patients were as follows: mean age was 64.3 years, 9% had a private health insurance, 9.4% of patients had a metastatic BC. After 1 year of follow-up, 17.4% of patients at GPs and 19.2% at gynecologists were diagnosed with depression or anxiety. There was a significantly higher risk of depression/anxiety in the age groups 41-50 (HR: 1.27, p<0.001) and 51-60 (HR: 1.30, p<0.001) compared to <=40 years. There was a much higher risk of depression/anxiety in patients with metastatic breast cancer (HR: 1.20, p<0.001) and patients with depression/anxiety episodes in the past (>1 year prior to indexdate (HR: 1.91, p<0.001). Private health insurance was associated with a significantly lower depression/anxiety risk (HR: 0.43, p<0.001). **CONCLUSIONS:** Analysis of real-world data from German primary care practices identified potential risk factors for the development of depression/anxiety disorder among BC patients. Being aware of these risk factors could facilitate early prevention and support for affected patients with potentially beneficial implications for their overall therapy. Further research has to be done to investigate these risk factors in more detail.

PCN11

THE EFFECT OF GLUCOSE LOWERING DRUG USE ON OVERALL MORTALITY AMONG BREAST CANCER PATIENTS

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OBJECTIVES: This study assesses the effect of glucose lowering drug (GLD) use, i.e. metformin, sulfonylurea derivatives (SUs), insulin and other GLDs, started after breast cancer diagnosis, on overall mortality. **METHODS:** All female breast cancer patients diagnosed between January 1st, 1998 and December 31st, 2011 who started using GLDs after breast cancer diagnosis, were included. Clinical characteristics were derived from the Netherlands Cancer Registry, drug dispensing data from the PHARMO Database Network and data on overall mortality from the Dutch municipal personal records database. Time-dependent Cox regression analysis, with cumulative exposure to GLDs were conducted to assess effects on overall mortality. **RESULTS:** In total, 407 breast cancer patients were included. Most women (n=335, 82%) used metformin at some point during follow-up, followed by SUs (n=202, 50%), insulin (n=58, 14%) and other GLDs (n=41, 10%). The average follow-up was 7.7 ± 3.6 years and 107 (26%) patients died during follow-up. Adjusted analyses showed that metformin users had a lower overall mortality (HR=0.47; 95%CI:0.29-0.74), while insulin users had a higher overall mortality (HR=1.85; 95%CI:1.09-3.15) compared to non-users. However, when assessing dose-response effects no association was found between cumulative use of metformin, SU, insulin or other GLDs and mortality. **CONCLUSIONS:** GLDs were not associated with mortality among patients who started using GLDs after breast cancer diagnosis. We did observe a lower mortality among breast cancer patients using metformin and higher mortality among patients using insulin. However, as no dose-response relationship was observed, the found effects on mortality are likely to result from differences in patient characteristics that we could not adjust for and not from the drugs itself. Larger studies with longer follow-up among patients who start using GLDs after cancer diagnosis are needed to confirm our findings.

PCN12

MORTALITY REDUCTION FROM GASTRIC CANCER BY ENDOSCOPIC SCREENING: 6-YEARS FOLLOW-UP OF A POPULATION-BASED COHORT STUDY

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OBJECTIVES: To evaluate reduction whether endoscopic screening reduces mortality from gastric cancer, a population-based cohort study was performed in Japan, where both radiographic screening and endoscopic screening for gastric cancer have been conducted. **METHODS:** The subjects were selected from among participants in gastric cancer screening in 2 cities (Tottori and Yonago) from 2007 to 2008. The subjects were defined as participants aged 40-79 years with no gastric cancer screening in the previous year. Follow-up related to mortality was continued from the date of the first screening to the date of death or up to December 31, 2013. A Cox proportional hazards model was used to estimate the relative risks (RRs) of incident gastric cancer, gastric cancer death, all cancer deaths except gastric cancer death, and all-cause death except gastric cancer death. **RESULTS:** The subjects were 9,950 participants in endoscopic screening and 4,324 participants in radiographic screening. The endoscopic screening group showed a 67% reduction from gastric cancer compared to that of radiographic screening group (RR adjusted by sex, age group, and city of residence = 0.327, 95%CI: 0.117-0.905). The adjusted RR of endoscopic screening was 0.966 (95%: 0.674-1.385) for all cancer deaths except gastric cancer death and 0.932 (95%:0.742-1.170) for all-cause deaths except gastric cancer death. **CONCLUSIONS:** The results of the present study suggest that endoscopic screening can decrease mortality from gastric cancer by 67% compared with radiographic screening. The results are consistent with the previous studies that showed that endoscopic screening reduces mortality reduction from gastric cancer.

PCN13

THERAPY OF DEPRESSION IN CANCER AND NON-CANCER PATIENTS IN GERMAN NEUROPSYCHIATRIC PRACTICES

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OBJECTIVES: It is known that patients with cancer are more at risk of becoming depressant. However, there is lack of information about how these patients are treated. The purpose of this study was to investigate if cancer patients are treated differently to non-cancer depression patients. **METHODS:** Using IMS® Disease Analyzer, patients were selected who were initially diagnosed with depression following cancer diagnosis between January 2004 and December 2013 from neuropsychiatrists (NP). Based on age, gender, health insurance and index year patients with prior cancer diagnosis were matched with a control group of patients who had no cancer diagnosis. The share of patients with a medical therapy within one year after depression diagnosis and the proportion of patients treated with tricyclic antidepressant (TA), selective serotonin reuptake inhibitors (SSRI), serotonin and norepinephrine reuptake inhibitors (SSRNI) or benzodiazepines (BZD) were analyzed. **RESULTS:** The study population consisted of 604 depression patients with and 604 without cancer (mean age 63.8 years, 36.5% male, 6.0% with private health insurance). In the cohort of cancer patients 27.6% had a breast cancer, 13.3% malignant neoplasms of lymphoid or hematopoietic tissue, 12.5% brain tumor, 8.3% prostate cancer, 10.0% cancer of digestive organs. 66.5% of patients with cancer and 72.8% without cancer received prescriptions of antidepressant drug (p=0.017). There were no significant differences in shares of SSRI/SSNRI (32.7% of cancer and 34.1% of non-cancer patients). TA were given less often in cancer patients (31.2% versus 38.2%, p=0.011), BZD slightly more often in cancer patients (7.0% versus 4.2%, p=0.033). **CONCLUSIONS:** Our studies showed that cancer patients receive slightly less and different antidepressant drug treatment than non-cancer patients. In further studies it should be analyzed what the reasons for the treatment decisions and what the patient health outcomes are.

PCN14

LONG-TERM TRENDS IN DESCRIPTIVE EPIDEMIOLOGY OF MALIGNANT MELANOMA IN THE SLOVAK REPUBLIC

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OBJECTIVES: The latest available national data from the Slovak Republic (SR) are for year 2008. The objective of this paper was to analyze and prospectively predict long-term national trends of malignant melanoma (MM) incidence, mortality, clinical stages and prevalence to obtain more actual data for the purpose of cost-of-illness studies and budget impact analysis in the SR. **METHODS:** Time-trends of national data on incidence, mortality, clinical stages and prevalence of MM in 1968-2008 were analyzed by using joint-point regression (Version 4.1.1.5). The data were predicted to the current year 2015. The trends are presented with a corresponding 95% Confidence Intervals (CI) and p-value with null hypothesis being constant with time. **RESULTS:** Epidemiological trends: In males (y.2008), MM age-standardized incidence represented 9.0/100,000 (n=315 cases, mean age=63.8 y.), with the last annual percentage change (APC) of 5.3% in 1995-2008 (95%CI=3.5-7.1, p<0.0001), estimated incidence for 2015 is 13.49/100,000 (95%CI ±0.637). Mortality in 2008 represented 2.3/100,000 (n=85) with the last APC 2.2% (95% CI=1.6-2.8, p<0.0001), estimation 2015 is 3.15/100,000 (95%CI ±0.159). In females (y.2008), MM incidence was 7.5/100,000 (n=330, mean age=60.27 y.), with the APC 3.5% (1968-2008, 95%CI=3.1-3.8, p<0.0001), estimation 2015 is 10.55/100,000 (95%CI ±0.164). Mortality in 2008 represented 1.5/100,000 (n=74), APC 0.53% in 1988-2008 (95% CI=-0.6-1.6, p=NS), estimation 2015 represents 1.73/100,000 (95%CI ±0.378). National prevalence in 2015 for both sexes represents 8.626 cases. We estimate 65.6% patients diagnosed in the 1st clinical stage, 22.44% in the 2nd, 1.54% in the 3rd, 6.03% in the 4th and 0.18% in the undefined clinical stage. The number of cases in the 1st stage is increasing during the time, however, the 4th stage remains stable. **CONCLUSIONS:** Actual data on prevalence and clinical stages of MM in the SR can be used as the source for setting the size of population in cost-of-illness studies and budget-impact analysis.

PCN15

PATTERNS OF METACHRONOUS METASTASES AFTER CURATIVE TREATMENT OF BREAST CANCER

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OBJECTIVES: To evaluate the patterns of metachronous metastases in patients with breast cancer. **METHODS:** Patients diagnosed with non-metastatic (M0) breast cancer at initial diagnosis between 2006-2008 were selected from the Eindhoven Cancer Registry, which is a population-based registry and records data on newly diagnosed cancer patients. By means of active follow-up, additional data on date of diagnosis and localization of metachronous metastases were collected directly from the patient files. Anatomical sites of metastasis were registered according to the International Classification of Diseases for Oncology (ICD-0). Proportions of metachronous metastases between tumour and treatment characteristics were compared using the Chi2 test. A p-value <0.05 was considered significant. **RESULTS:** There were 1,382 patients diagnosed with M0 breast cancer with a mean (±SD) age of 60.3 (±13.8) years. Of those, 116 patients (8%) developed metachronous metastases during a median (±SD) follow-up of 4.1 (±1.1) years. The mean (±SD) age at the time of diagnosis of metachronous metastases was 61.7 (±14.3) years. Diagnosis of metachronous metastases was confirmed by imaging in 76 patients (66%), in 39 patients (34%) by histopathology and 1 patient (1%) based on clinical symptoms. The most frequent metastatic sites affected were bone (29%) and liver (17%). Breast cancer patients who developed metachronous metastases were significantly more often diagnosed with a hormone receptor positive and a HER2-negative tumor, had a poor tumor grade, had a tumor size greater than 2.1 cm, and more often received chemotherapy at initial breast cancer diagnosis. **CONCLUSIONS:** Of the initially M0 breast cancer patients, 8% developed metachronous metastases, of which one-third developed bone metastasis. The risk of developing metachronous metastases varies among different characteristics at initial breast cancer diagnosis. Identifying the patterns of metachronous metastases and characteristics increasing the risk for developing metachronous metastases contributes to tailored follow-up and adequate initial M0 breast cancer treatment.

PCN16
TREATMENT STRATEGIES FOR ELDERLY PATIENTS WITH NEWLY DIAGNOSED MULTIPLE MYELOMA: A META-ANALYSIS AND INDIRECT TREATMENT COMPARISON

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OBJECTIVES: Elderly patients with newly diagnosed multiple myeloma (MM) are usually not considered for stem cell transplantation. Treatment alternatives include multidrug regimens combining prednisone (P)/dexamethasone (D), thalidomide (T), bortezomib (V), cyclophosphamide (C), and melphalan (M). Head-to-head comparisons between the different treatments are lacking. We compared the effectiveness of different first-line treatment strategies for patients with MM (age > 65 years) in terms of progression-free survival (PFS) and overall survival (OS). **METHODS:** We performed a systematic literature search in MEDLINE, EMBASE, Cochrane Library and CRD databases. The primary search yielded 2,673 citations. Ten randomized controlled trials (RCT), enrolling a total of 3,782 patients, were included in our meta-analysis and indirect treatment comparisons. We calculated pooled hazard ratios (HR) with 95% confidence intervals (95%CI). **RESULTS:** Meta-analysis of six RCTs comparing MPT vs. MP showed a statistically significant benefit of MPT in PFS (HR 0.75, 95%CI 0.64-0.88) but no statistically significant difference in OS (HR 0.90, 95%CI 0.75-1.08). The indirect comparison of MPT vs. MPV showed a benefit in PFS for MPV (HR 1.41, 95%CI 1.04-1.90) but no OS difference (HR 1.29, 95%CI 0.98-1.70) using MP regimen as the common comparator. There was no difference between MPT vs. CTD, indirectly analyzed with MP as common comparator (PFS: HR 0.91, 95%CI 0.73-1.14; OS: HR 1.01, 95%CI 0.78-1.32). Indirect comparison was also possible for VMPT-VT vs. VTD, both compared to MPV in the original RCTs. VMPT-VT showed a statistically significant benefit in PFS (HR 0.48, 95%CI 0.33-0.71) but no difference in OS (HR 1.04, 95%CI 0.69-1.59) compared to VTD. **CONCLUSIONS:** While some regimens showed improved PFS, there was no evidence for a benefit in OS comparing the different treatment strategies. Combining all treatment strategies based on published data by using a network meta-analysis may help to identify the optimal treatment option.

PCN17
BAYESIAN NETWORK META-ANALYSIS TO ASSESS RELATIVE EFFICACY OF IBRUTINIB VERSUS IDELALISIB+OFATUMUMAB AND PHYSICIAN'S CHOICE IN RELAPSED/REFRACTORY CLL PATIENTS

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OBJECTIVES: To assess the relative efficacy of ibrutinib (IBR), a first-in-class BTK-inhibitor, versus Idelalisib+ofatumumab (IDEL+OFA) and physician's choice in relapsed/refractory (R/R) CLL-patients using Bayesian Network Meta-Analysis (NMA). **METHODS:** Three RCTs in R/R CLL-patients were identified with OFA as common treatment arm. IBR (Byrd, 2014) and IDEL+OFA (Jones, 2015) showed improved investigator-assessed PFS (HR=0.13 and 0.27, respectively) and OS (HR=0.39 and 0.74, respectively) versus ofatumumab in R/R CLL-patients. Osterberg (2014) compared PFS (INV) (HR=0.56) and OS (HR=0.72) for OFA to physician's choice (PC), a mix of well-established CLL-treatments, in more severe patients. A Bayesian NMA was conducted in line with NICE guidelines, using a fixed-effect model with non-informative priors. Posterior distributions for the HR were summarized by median values and 95% credible intervals. **RESULTS:** HR for PFS (INV) comparing IBR vs IDEL+OFA and PC were 0.49 ([0.28;0.87],P(HR<1)=99.2%) and 0.07 ([0.04;0.13],P(HR<1)=100%), respectively. HR for OS comparing IBR vs IDEL+OFA and PC were 0.52 ([0.24;1.14],P(HR<1)=94.7%) and 0.28 ([0.13;0.80],P(HR<1)=100%), respectively. DISCUSSION : In absence of head-to-head trials, indirect comparisons can provide useful insights to clinicians and reimbursement-decision making on relative efficacy of treatments. The probabilistic interpretation of Bayesian results suits these purposes, allowing probabilistic statements on which treatment is likely to be the most effective. Bayesian probabilities and credible intervals have different interpretation than classical p-values and confidence intervals. Bayesian results fit well in decision modelling, as resulting posterior distributions can serve as priors in probabilistic cost-effectiveness modelling. Assumptions behind NMA to generate unbiased results were considered valid for IBR vs IDEL+OFA-comparisons, as included patient-populations were nearly identical. Estimates versus PC may be conservative, given higher relative treatments effect in more severe patients. **CONCLUSIONS:** In absence of direct evidence, NMA-results suggest improved PFS and OS for IBR compared to IDEL+OFA and to PC in R/R CLL-patients with high certainty, and can serve as input in HTA-decision modelling.

PCN18
ASSESSMENT OF MAJOR MOLECULAR RESPONSE (MMR) AND COMPLETE CYTOGENETIC RESPONSE (CCYR) AS SURROGATE OUTCOMES OF SURVIVAL IN CHRONIC MYELOID LEUKEMIA CHRONIC PHASE (CML-CP) PATIENTS

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OBJECTIVES: This study aims to investigate the association of the major molecular response (MMR) and complete cytogenetic response (CCyR) as surrogate outcomes with overall survival (OS) and progression free survival (PFS) in chronic phase of chronic myeloid leukemia (CML-CP) patients using evidence from observational or experimental study. **METHODS:** We conducted using existing systematic reviews and meta-analysis to quantify the association between CCyR and/or MMR at 12 months and OS and/or PFS. The overall survival rate or progression free survival rate according to the responders or non-responders of MMR or CCyR at 12 months after the initiation of first-line TKI therapy (imatinib, dasatinib or nilotinib) was extracted by two independent reviewers. A weighted average of the OS and PFS at different yearly intervals was estimated respectively for both the responders and non-responders with assumption of no censoring. The analyses were carried out using R package "metafor". **RESULTS:** Eleven studies provided data on the association between CCyR or MMR and OS or PFS after imatinib treatment however there were no such studies about dasatinib or nilotinib treatment. Patients who experience CCyR following 12 months' TKI therapy have better long-term (7 –year) OS and PFS (OS 97.0% vs 82.5; PFS 97.0% vs 69.6%) than patients who are non-responders at 12 months. Patients who experience MMR at 12 months' TKI therapy have better long-term (5-year) OS and PFS (OS 99.4% vs 93.4%; PFS: 89.9% vs 85.3%). **CONCLUSIONS:** This study identified evidence of the association between CCyR and/or MMR and survival among the TKI treated CML-CP patients, and this is based entirely on imatinib treatment studies. The evidence of dasatinib and nilotinib is limited by the amount and quality of data available. Therefore further research is needed whether this relationship between the surrogate outcomes and final outcomes are equally applicable to dasatinib and nilotinib.

PCN19
COMPARISON OF TREATMENT DURATION AMONG TARGETED AGENTS IN RENAL CELL CARCINOMA (RCC)

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OBJECTIVES: Conducting comparative effectiveness research among multiple classes of treatments may inform optimal treatment based on the real-world effectiveness. We conducted a retrospective analysis comparing the duration of six leading treatment options in renal cell carcinoma stratified by line of therapy. **METHODS:** Using claims data (MORE2 Registry), patients with renal cell carcinoma who started and completed at least one line of treatment during the study period (January 2012 to February 2014) were identified by ICD9 code 189.0. Line of therapy (LOT) was assigned based on the patient's available treatment history. Analysis was stratified by LOT. Univariate analysis of variance was performed to compare mean durations among treatment options, LOT, and therapeutic class. Multivariate analysis controlling for demographic and treatment characteristics will be presented in the poster. **RESULTS:** Patients received 1240 complete lines of therapy. Mean duration of treatment by line of therapy was as follows: 1st LOT: 4.0 mo (n=599); 2nd LOT: 3.2 mo (n=357); 3rd LOT 3.1 mo (n=284). There was statistically significant difference in mean duration of therapy between the groups of patients by second line regimen (p=0.003). Within the second line patient group the tyrosine kinase inhibitor (TKI) treated patients had greater duration compared to the mammalian target of rapamycin (mTOR) treated patients (3.5 mo vs 2.6 mo, p-value=0.006). However no difference in duration was observed among first (p=0.7239) and third line regimens (p=.0.6476). **CONCLUSIONS:** In this study there was statistically significant difference in duration among leading systemic agents used for second-line treatment of RCC where patients were shown to remain on TKI treatment longer than mTOR treatment. Future research should determine if toxicity and costs influence duration in this therapeutic area.

PCN20
EVALUATION OF PATTERNS OF CARE IN RENAL CELL CARCINOMA (RCC): HIGH UNMET NEED PERSISTS

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OBJECTIVES: Understanding prescriber perceptions of efficacy and tolerability among available RCC treatments in a real-world population may inform current areas of unmet need and provide context for the adoption of new therapeutics. We conducted a retrospective analysis evaluating the drug utilization patterns and duration of tyrosine kinase inhibitors (TKI) and mammalian target of rapamycin (mTOR) inhibitors in patients with newly diagnosed and relapsed RCC. **METHODS:** Using claims data (MORE2 Registry), patients with RCC who completed at least one