in a hypothetical ten-million-member health plan over a 3-year horizon. Estimates of cancer rates and utilization of HEC and MEC therapies were derived from epidemiological and market data. Treatment costs were computed using standard prescribing dosages, U.S. drug cost listings and simple reimbursement and dis-

assumptions. Uptake of NEPA was calculated at 5% a year for 3 years, and costs of antiemetic therapies were reduced proportionately based on initial share assumptions. RESULTS: A total of 54,000 patients with cancer were identified in the model scenario. Of these, 9,882 (18.3%) would receive HE and 9,349 (7.3%) would receive MEC requiring combination therapy, for a total of 13,230 eligible for NEPA. Cost of CINV prevention prior to the adoption of NEPA was estimated at $40.96 mil-

lion. Following adoption of NEPA, cumulative costs were reduced by nearly $652K by the end of year 3. Calculations using PAMM estimates showed cumulative savings of $8,000 per year in year 1 and $8,005 in year 2. CONCLUSIONS: Results of the model indicate that adoption of NEPA for the prevention of CINV may have a relatively neutral impact on a U.S. health plan budget. Additionally, these estimates do not include savings from a potential reduction in the overall rate of CINV.

PCN35
LUNG CANCER ECONOMIC BURDEN FROM A PRIVATE HEALTHCARE SYSTEM PERSPECTIVE IN BRAZIL

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OBJECTIVES: To evaluate the cost of lung cancer treatment in Brazil from the perspective of private hospitals and identify the major cost drivers.

METHODS: Orion administrative claims database containing over 18 million lives was used to identify patients with lung cancer using the following ICD-10 codes: C34, C34.9, C34 A, C34.3, C34.8, C34.9. The period between the beginning of November 2010 and October 2013. Only patients receiving traditional chemotherapy for their lung cancer were included in the analysis. RESULTS: A total of 11,348 patients were identified with lung cancer over the study period. This group included 54% men, 62% aged 30 to 60 years, 60% aged 60 to 70 years and 4 years old on average, and received treatment for a mean duration of 5.5 months. Of the 11,348 patients, 3,076 were hospitalized and 8,272 received outpatient care. Forty-

nine percent of these hospitalizations were received by patients who were hospitalized, each patient had, on average, 4.63 hospitalizations with an average length of stay of 9.55 days. The average cost per patient hospitalized was BRL 34,904, with approximately 25.67% of the total hospital cost spent on drugs and the remainder spent on fees, supplies, exams and procedures (24.41%, 37.31%, 5.71% and 6.89% respectively). For outpatient care, the average cost per patient was BRL 22,746 with 87.61% of the total outpatient care spent on drug expenses and the remaining 12.39% spent on fees, supplies, exams and procedures (1.73%, 40.04%, 5.17% and 2.88% respectively). CONCLUSIONS: The economic burden of lung cancer in Brazil could be reduced especially in outpatient care if oral treatments instead of infusion-based treatments were used (e.g., avoidance of infusion-related resources such as fees, procedures and supplies), which could represent a reduction of 8.63% or BRL 1,956 per lung cancer patient.

PCN36
THE UTILIZATION OF LAPAROSCOPIC VERSUS OPEN LIVER RESECTION FOR HEPATOCELLULAR CARCINOMA OR SECONDARY COLORECTAL METASTASES: A BUDGET IMPACT ANALYSIS

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OBJECTIVES: Clinical research has demonstrated that laparoscopic resec-

tions provide oncologically equivalent patient outcomes when compared to open liver resection, while also providing a statistically significant reduction in postoperative complica-

tions. Approximately 16% of all liver resections in Canada are performed laparoscopically. The objective of this study is to compare the costs associated with traditional liver resection vs. laparoscopic liver resection, with oncologically equivalent patient outcomes.

METHODS: This study was conducted to determine the budget impact of increasing the propor-

tion of laparoscopic vs. open liver resection in a Canadian hospital. METHODS: We examined the budget impact of increasing the percentage of laparoscopic liver resections from 16% to 40%, while decreasing the number of open cases proportion-

ately in a hospital that performs 50 resections annually. The model incorporates the costs associated with surgery, length of stay (taking into account facility and staff costs) and postoperative complications. The cost data used in the model was obtained from peer reviewed literature, the Ontario Cancer Care Initiative and costing data from a large Canadian hospital. Data on patient outcomes was obtained from published meta-analyses. A multivariate sensitivity analysis using a Monte Carlo simulation was completed to ensure scientific rigour. RESULTS: Laparoscopic liver resections are associated with higher device costs, but similar overall procedure costs. The additional device cost is offset by a shorter length of stay and lower rate of post-operative complications. The model establishes that for a Canadian hospital performing 50 liver resections increasing the proportion of laparoscopic cases from 16% to 40% allows for a potential cost savings of CAD $50,730 annually. CONCLUSIONS: In a Canadian hospital, laparoscopic liver resec-
tions are a more cost-effective treatment for hepatocellular carcinoma or secondary colorectal metastases when compared to open resection.
of public healthcare in Ecuador to predict the financial consequences of introducing axitinib as a line of treatment in Ecuadorian patients. Costs were projected to be $35,270 for dabrafenib-trametinib combination, $27,043 for vemurafenib, $22,634 for dabrafenib, and $19,029 for trametinib.

CONCLUSIONS: The addition of user-modifiable projected reimbursement revenue calculation is a valuable tool that expands the contribution of economic modeling to hospital formal decision-making.

PCN40

UNIVERSAL VERSUS TARGETED SCREENING OF COLON CANCERS FOR LYNCH SYNDROME: COST AND DIAGNOSTIC EFFECTIVENESS ANALYSES BASED ON CLINICAL EXPERIENCE
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OBJECTIVES: Strategies for screening incident colorectal cancers (CRC) for Lynch syndrome (LS) are evolving rapidly. Our objective is to compare the diagnosticistic results and costs from two strategies for LS screening: Targeted Screening (TS) and Universal Screening (US) of tumors for mismatch repair (MMR) abnormalities. METHODS: For 18-months in 2010-2011, we employed TS - individual's under colonoscopy; TS was limited to individuals with a first-degree relative (FDR) with CRC. Immuno-histochemical (IHC) staining for the four MMR proteins was done in all cases. Microsatellite instability, BRAF mutation, MLH1 promoter methylation testing, and/or genetic testing of gern line DNA were done in selected cases. We compared the diagnostic costs of several strategies for detecting LS and the downstream costs of prevention CRC through colonoscopy screening, using a system dynamics model, built in the “Anylogic” program. RESULTS: In 2010-2011, 51 of 175 (29%) incident CRCs were screened by US using TS strategy, 15(29%) showed abnormal loss of 1 MMR protein. Germ line MMR gene mutations were found in 4 cases and were unsuspected but not demonstrated in 11 additional cases. In 2012-2013, 194 CRCs were screened by IHC using TS and 13(6.7%) had abnormal staining suspicious for LS. MMR mutations were found in only 2/9 cases abnormal for IHC. Cost to identify the LS probands was ~8,339/LS case diagnosed for targeted screening (four mut-ations), whereas for LS case diagnosed for universal screening (two mutator carriers/24 months). CONCLUSIONS: Real-world results were more complicated than anticipated. Results from US with IHC were often atypical, not diagnostic of LS. Economic analysis using our costs suggests that TS is less costly than US, but it cases of mildly penetrant LS. US identifies changes that are currently of unknown significance but that have potential to contribute to future research into the mechanisms of CRC tumorigenesis.

PCN41

PROSTATE CANCER BURDEN IN ARGENTINA: COSTS, MORTALITY AND READMISSIONS
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OBJECTIVES: Little is known about cancer (CA) in hospitalization, cost and outcomes in Argentina. We studied this in a multicentric hospital study in Argentina. METHODS: Adult CA, hospital direct costs, re-admissions (ReH <30 days) and deaths in 1 yr output of 3 academic hospitals. Cost and results, harmo- nized according HCUPS (USA) terminology groups, of primary (1Dx), and secondary diagnosis (2Dx) for each Cx code (Clinical Classification Software-CSS single level SL-2009). Total costs (CT$), mean costs (SD) and median per discharge cost ($) for 520 disch., 5,54% (4,75-5,15). Among CA 45,466 ≥ 18 old, CA was found in 6,282, 18.13%(95%CI 15,50-16,44) Dx, 1,608 PPP, 2008 (CA). Defined (4656) from CA (4656 in 4,64,44,44,44) #44 cost in 6,282, 18.13%(95%CI 13,50-14,14) Dx, 1,608 PPP, 2008 (CA). Cost and results, harmo- nized according HCUPS (USA) terminology groups, of primary (1Dx), and secondary diagnoses (2Dx) for each Cx code (Clinical Classification Software-CSS single level SL-2009). Total costs (CT$), mean costs (SD) and median per discharge cost ($) for 520 disch., 5,54% (4,75-5,15). Among CA 45,466 ≥ 18 old, CA was found in 6,282, 18.13%(95%CI 15,50-16,44) Dx, 1,608 PPP, 2008 (CA). Defined (4656) from CA (4656 in 4,64,44,44,44) #44 cost in 6,282, 18.13%(95%CI 13,50-14,14) Dx, 1,608 PPP, 2008 (CA). Cost and results, harmo- nized according HCUPS (USA) terminology groups, of primary (1Dx), and secondary diagnoses (2Dx) for each Cx code (Clinical Classification Software-CSS single level SL-2009). Total costs (CT$), mean costs (SD) and median per discharge cost ($) for 520 disch., 5,54% (4,75-5,15). Among CA 45,466 ≥ 18 old, CA was found in 6,282, 18.13%(95%CI 15,50-16,44) Dx, 1,608 PPP, 2008 (CA). Defined (4656) from CA (4656 in 4,64,44,44,44) #44 cost in 6,282, 18.13%(95%CI 13,50-14,14) Dx, 1,608 PPP, 2008 (CA). Cost and results, harmo-