PCN112 COMPARISON OF CHARACTERISTICS OF COLORECTAL CANCER PATIENTS ADMITTED EMERGENTLY, URGENTLY OR ELECTIVELY IN WEST VIRGINIA HOSPITALS BETWEEN 2003-2007
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OBJECTIVES: Colorectal cancer poses a significant disease burden in West Virginia. Hospitalization followed by surgical resection is the standard curative treatment. Emergency admissions account for more than 25% of colorectal cancer hospitalizations nationwide. The aim of this study is to compare characteristics of West Virginia residents admitted emergently, urgently or electively to West Virginia hospitals between 2003-2007. Another aim was to explain the association between admission type and in-hospital deaths.
METHODS: Data from the Healthcare Cost and Utilization Project (HCUP), State Inpatient Database were investigated. Descriptive statistics for admission type, comorbidities, in-hospital death, age and sex were tabulated. Chi-square analyses helped explain differences in characteristics between emergency and elective admissions.
RESULTS: There were 9380 admissions with a primary or secondary diagnosis of CRC of which 33.1% were emergency admissions, 24.4% urgent and 42.1% elective. Of the in-hospital deaths more than half (50.5%) the cases were admitted emergently compared to electively (23.1%). Among emergency and urgent admissions the most common comorbid conditions were diabetes (17.1%), followed by fluid disorders (6.9%) and hypertension (5.0%). Among elective admissions diabetes (19.9%) was followed by COPD (4.3%) and hypertension (3.5%). Logistic regression showed that the odds of in-hospital death were 3.03 times higher for emergency admission compared to elective after controlling for age, sex, number of comorbidities, diagnosis type and payer. CONCLUSIONS: Patients admitted emergently are more likely to die in-hospital compared to those admitted electively. The large percentage of post-diagnosis emergent indicates advanced disease and possibly failure of timely screening. Comorbid conditions differed by admission type and need further investigation. Diabetes was the most common comorbid condition overall and further investigation in diabetics is needed to check screening behavior and access to screening centers.

PCN113 LEARNING THE LESSONS OF ONCOLOGY HTA REVIEWS IN AUSTRALIA & THE UNITED KINGDOM – A CASE STUDY OF FIVE DRUGS
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OBJECTIVES: HTA agencies have different requirements and preferences in terms of both the models they review and the clinical evidence that submission are based on. Our aim was to understand what could be learned about the preferences of PRAC in Australia and NICE and the SMC in the UK specific to oncology from five selected case studies.
METHODS: Five high-profile cancer drugs, namely Avastin (bevacizumab), Erbitux (cetuximab), Sprycel (dasatinib), Tykerb/Tyverb (lapatinib) and Taxotere/Docetaxel (docetaxel) were selected as our research sample. All assessment guidelines, decisions and the drugs’ labelling were reviewed.
RESULTS: Avastin has been one of the most rejected drugs among the three agencies, with the exception of PRAC’s recommendation of listing for 1st line metastatic colorectal cancer. This was on the condition of a patient access scheme to increase to the overall drug cost by including Avastin in the treatment regimen has been the main concern with other negative factors including the inappropriate choice of comparators.Tykerb received negative recommendations from both PRAC and SMC for breast cancer due to concerns over small trial population size, robustness of efficacy evidence as well as high BCR. Between the 5 drugs, 21 HTA reviews took place, resulting in 11 positive recommendations, 10 rejections and 1 deferred decision for further price negotiation. Out of the positive recommendations, 4 were based on risk sharing arrangements. CONCLUSIONS: HTA agencies respond differently to submissions based on the same clinical dossier. Understanding in detail what the evidence preferences are of the individual agencies is crucial of the probability of reimbursement is to be maximised. This understanding should be fed into clinical development and supplementary evidence plans.

PCN114 DEVELOPING A FAMILIAL CANCER RISK ASSESSMENT TOOL FOR USE IN UNDERSEVERED COMMUNITIES
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OBJECTIVES: Considering human factors in new technology is essential to ensure its acceptance, particularly in underserved communities. This study assessed the usability of the original (Flash) and new (HTML) versions of a self-administered familial cancer risk assessment tool-the Jameslink. METHODS: The study was a randomized, hybrid experimental design involving in-person usability testing of the original (Flash) and new (HTML) versions of a self-administered familial cancer risk assessment tool-the Jameslink. METHODS: Data from the Healthcare Cost and Utilization Project (HCUP), State Inpatient Database were investigated. Descriptive statistics for admission type, comorbidities, in-hospital death, age and sex were tabulated, chi-square analyses helped explain differences in characteristics between emergency and elective admissions.
RESULTS: There were 9380 admissions with a primary or secondary diagnosis of CRC of which 33.1% were emergency admissions, 24.4% urgent and 42.1% elective. Of the in-hospital deaths more than half (50.5%) the cases were admitted emergently compared to electively (23.1%). Among emergency and urgent admissions the most common comorbid conditions were diabetes (17.1%), followed by fluid disorders (6.9%) and hypertension (5.0%). Among elective admissions diabetes (19.9%) was followed by COPD (4.3%) and hypertension (3.5%). Logistic regression showed that the odds of in-hospital death were 3.03 times higher for emergency admission compared to elective after controlling for age, sex, number of comorbidities, diagnosis type and payer. CONCLUSIONS: Patients admitted emergently are more likely to die in-hospital compared to those admitted electively. The large percentage of post-diagnosis emergent indicates advanced disease and possibly failure of timely screening. Comorbid conditions differed by admission type and need further investigation. Diabetes was the most common comorbid condition overall and further investigation in diabetics is needed to check screening behavior and access to screening centers.

PCN115 TRANSFERABILITY OF NICE RECOMMENDATIONS FOR PHARMACEUTICAL THERAPIES IN ONCOLOGY TO CENTRAL-EASTERN EUROPEAN COUNTRIES
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OBJECTIVES: The health status of the population of Central-Eastern Europe (CEE) is worse than that of Western Europe, this is especially true for malignant diseases. Furthermore, these countries have more limited health care resources; therefore, transparent decision criteria, including the assessment of cost-effectiveness in formal health technology assessments (HTA), are an absolute necessity. Unfortunately, the number of trained health economists and prospective health economic trials and the public budget for HTA are not comparable to the major markets of innovative health technologies, such as those of the United Kingdom. Transferability of good quality HTA reports, especially those prepared by the National Institute for Health and Clinical Excellence (NICE), could be highly beneficial to prevent the duplication of efforts and to save resources for local health technology assessments.
METHODS: We scrutinized the transferability of 68 published NICE appraisals of innovative oncological drugs to CEE countries. The most critical factors for the transferability of NICE appraisals were selected based upon differences in measures between UK and CEE countries. RESULTS: In general, we can conclude that HTA recommendations by the NICE are not transferable. Certain elements of HTA reports are transferable, but adjustment to local data is absolutely necessary. If the NICE recommendation is positive, the conclusion can be still negative in CEE countries; this is primarily due to relative price differences and the significance of local budget impacts. If the NICE recommendation is negative, the innovative health technology can be still cost-effective in Central-Eastern Europe due to the worse health status of the population and the greater potential health improvement. CONCLUSIONS: Decision-makers in CEE countries cannot make excuses; they must improve the appropriateness of reimbursement decisions to increase the allocative efficiency of health care financing, but copying NICE recommendations without local adjustment may do more harm than good.