Abstracts

TREATMENT PATTERNS OF MEXICAN ONCOLOGISTS IN FIVE DIAGNOSIS GROUPS

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OBJECTIVES: There is no evidence about real medical practice in oncology in Mexico. The objective of this study was to explore current medical practices of Mexican oncologists in the management of five malignancies: breast, non-small cell lung (NSCLC), colon, rectum and kidney cancer. METHODS: A specific instrument for these malignancies was developed, validated and applied to Mexican oncologists. Information requested reflects stage-specific treatment and disease management, including surgery and drugs used, as well as frequency of prescription, discontinuation and factors that determine them in public and private health care institutions, between January and April 2009. RESULTS: 30 oncologists were included: 63.3% from Instituto Nacional de Cancerología. 73.3% of all oncologists have public and private practices. Tamoxifen (adjuvant hormone therapy) and 5-fluorouracil/leucovorin/cisplatinphosphamide (adjuvant, neoadjuvant and palliative chemotherapy) are the most frequently drug schemes used in breast cancer, with no differences between public and private practices (p < 0.05). At least 85.0% of NSCLC cancer cases are diagnosed in IIB and IV stages; combination chemotherapy (platinumetoposide) is highly prescribed in NSCLC cancer patients undergoing radiotherapy or non-resectable disease. Colon cancer is diagnosed in stages III (58.0%) and IV (14.0%); 20.0% of colon cancer patients undergoes surgery (left or right hemicolectomy). Drug availability and medical guidelines recommendations drive prescription to treat colon cancer. Surgery in rectum cancer is applied at stages IIB, IIA and IB (17.4%, 20.0% and 16.9%, respectively). Rectum cancer presents as non-resectable disease in 60.0% of cases in stage IV. Drugs used to treat metastatic renal cell cancer are interferon-α (80.0%) and sunitinib (91.0%), prescription is driven by drug availability and efficacy, respectively. Discontinuation rate of interferon-α is 90.0%. CONCLUSIONS: Knowledge of oncology current medical practice provides a basis for evaluation, as well as supports decision making process and the generation of new strategies for policy makers.

TREATMENT PATTERN OF METASTATIC TRIPLE NEGATIVE BREAST CANCER IN COMMUNITY PRACTICE

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OBJECTIVES: Triple negative (TN) breast cancer (BC), a subtype of BC characterized by its unique molecular profile and aggressive clinical behavior, lacks satisfactory standard therapies. Little is known about how patients with TNBC were treated in community practice. This study was conducted to identify treatment patterns of first-line chemotherapy (CT) of TNBC using data from community practice. Methods: Analyses were conducted using the Georgia Cancer Specialist Database (GCSD 2003–2008) and the International Oncology Network’s Treatment and Outcomes Database (ION 2003–2008). In both data, patients with stage IV TNBC were selected and followed for up to one year since initial diagnosis. The first-line CT was identified if 1) the first drug was initiated within 120 days following the initial BC diagnosis; 2) other combination drugs be started within 30 days of the first drug. RESULTS: The study included 30 and 35 patients from GCSD and ION, respectively. In GCSD sample, 14 patients (47%) were treated with monotherapy, capcitabine and taxanes being dominant (10% and 43%, respectively); 16 patients treated with combination therapy, with combinationtherapy (CT) of CT or TNBC using data from community practice. Patients with TNBC. CONCLUSIONS: It appears that taxanes/capcitabine, and CT or CP were mostly used monotherapy and combination therapy, respectively, for stage IV TNBC. The patterns are rather diverse than convergent, reflecting lack of standard therapy for TNBC. Data from other community settings are needed to confirm these results.

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IMPROVING ASCERTAINMENT OF VITAL STATUS USING SOCIAL SECURITY DEATH MASTER FILE (SSDMF) AND THE NATIONAL DEATH INDEX (NDI)

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BACKGROUND: Ascertainment of vital status is critical to studies in many disease areas especially in oncology. Two commonly used sources for mortality are SSDMF and NDI, with NDI considered the gold standard. Limitations identified in previous studies are under-ascertainment associated with the former; time lag (1–2 years) and higher cost associated with the latter. OBJECTIVES: To compare ascertainment of vital status by consolidating mortality data from SSDMF and NDI vs. either source alone. METHODS: Patient identifiers for a cohort of 3764 cancer patients from a large US claims database were submitted to SSDMF (cutoff February 2009) and NDI (cutoff December 2007) to obtain vital status. Matching to SSDMF utilized SSN alone or a combination of last name, first name and birthdate. Matching to NDI utilized combinations of SSN and/or patient name, birthdate, and state of residence. For patients with a death date found in NDI, a variable indicating a true or false match was provided by NDI based on the probabilistic score. We derived the death date via a stepwise approach by utilizing all match results from either source. RESULTS: Of 3764 patients, SSDMF returned a match for 901 (24%) patients using SSN alone, and 1088 (29%) patients using the combination. From the NDI, 946 (25%) patients had a “true” match, 1408 (37%) had a “false” match, and remainder were considered alive. Comparing SSDMF and NDI results utilizing both true and false NDI matches, we derived death dates for 1326 patients, 47% and 40% more-compared to SSDMF by SSN alone or NDI true match, respectively. Eight patients had claims following death date and were considered false matches. CONCLUSIONS: Utilizing all match results from SSDMF and NDI identified significantly more deceased patients compared to either source alone. Misclassification of living patients as deceased appears minimal as verified by claims counts, in general signaling injection. Utilizing claims data can provide a real-world perspective on the epidemiology, treatment, outcomes, and costs associated with FN in cancer patients. However, identifying true cases of FN in claims data can be prob-

METODOLOGICAL ISSUES OF IDENTIFYING FEBRILE NEUTROPNENIA PATIENTS USING MEDICAL CLAIM DATA

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Febrile neutropenia (FN) is a condition that develops in cancer patients treated with myelosuppressive chemotherapy schemes. Characterized by fever and very low neutrophil counts, in general signaling injection. Utilizing claims data can provide a real-world perspective on the epidemiology, treatment, outcomes, and costs associated with FN in cancer patients. However, identifying true cases of FN in claims data can be prob-

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