pital admissions between the 2 groups. Total mean medical costs were significantly higher in MLD patients ($35,173) compared to HCC patients ($22,465, p < 0.001). Inpatient costs contributed 61% ($13,667) to the total cost in HCC patients compared to 45% ($14,349, p < 0.05) in MLD patients. Conversely, 46% ($16,006) of the total cost in MLD patients was due to physician costs (including chemotherapy), compared to only 27% ($6115, p < 0.001) in HCC patients. CONCLUSIONS: Among Medicare patients newly diagnosed with HCC or MLD, significantly higher 1-year health resource use and medical costs were found in MLD patients. The difference in overall costs was due primarily to higher physician (including office) costs among MLD patients. These findings provide important new data for evaluating the economic impact of treating HCC and MLD patients in the Medicare population.

PCN17
EVALUATING THE COST OF CARE FOR EARLY AND LATE STAGE OROPHARYNGEAL CANCER IN THE CALIFORNIA MEDICAID POPULATION
Epstein JD1, Knight TK1, Epstein JB2, Bride M3, Nichol MB1
1University of Southern California, Los Angeles, CA, USA, 2University of Illinois at Chicago, Chicago, IL, USA, 3Zila, Inc. Phoenix, AZ, USA
OBJECTIVES: To investigate the health care utilization and direct medical costs associated with treating early and late stage oropharyngeal cancer within the first year following diagnosis.
METHODS: A retrospective database analysis was conducted using California Medicaid claims data merged with mortality data for the years 1995 to 2003. Patients diagnosed with oropharyngeal cancer were identified using a 6-month wash-out period and were either continuously eligible for 12 months following diagnosis or had a recorded death within that year. Utilization of health care resources was assessed and direct Medicaid payments were calculated. Subgroup analysis was performed on patients with early and late stage disease as defined by their cancer treatment. Using treatment to define tumor stage was in accordance with Modi's 2005 review of the standard of care for treatment of squamous cell carcinoma of the head and neck. Regression was used to determine significant predictors of total one year Log cost of care in this population. RESULTS: We identified 322 who were diagnosed and treated for oropharyngeal cancer. The median one year cost of care for these Medicaid patients was $26,763. Total health care spending was 38.03% higher for patients who received early stage treatment and died within the year (p = 0.0164), 53.54% higher for patients who received late-stage treatment and survived the year (p = 0.0036), and 85.29% higher for patients who had late stage treatment and died within the year (p = 0.0033) compared with patients who received early stage treatment and survived. Comorbidities and their interaction with age were also significant (p < 0.01) in predicting Log costs. CONCLUSIONS: Oropharyngeal cancer is a significant cost from the insurer's perspective. In addition to improved prognosis and quality of life, early diagnosis may reduce the cost of care to the insurer and therefore efforts should be made to diagnose oral tumors at an earlier stage.

PCN18
CLINICAL AND ECONOMIC OUTCOMES OF INITIAL ACUTE MYELOBLASTIC LEUKEMIA (AML) HOSPITALIZATION IN THE ELDERLY
Nyts G1, Janagap C1, Zilberberg M2, Pich CT2
1Johnson and Johnson, Raritan, NJ, USA, 2Ortho Biotech Clinical Affairs, LLC, Bridgewater, NJ, USA
OBJECTIVES: AML in the elderly is characterized by high short-term mortality and economic burden, with hospitalizations as the main driver. We examined clinical and economic outcomes of the initial hospitalization in an elderly cohort with newly-diagnosed AML. METHODS: An analysis of the 2002 Premier Perspective inpatient database was performed in patients >65 years with a new diagnosis of AML. RESULTS: A total of 509 (46% female) patients accounting for 803 hospital admissions, met the inclusion criteria. There was an equal proportion of patients in the groups aged 65–74 and >75. Of the 183 (36%) patients receiving chemotherapy (CT) on first admission, 41% received standard induction (SI), 31% non-SI and 27% hydroxyurea (H). Among CT group, more SI patients were younger than non-SI patients (73% and 51% 65–74yrs, respectively), while fewer non-CT and H patients were younger (39% and 32%, 65–75yrs, respectively). CT patients were less likely to have comorbidities (8%) compared to non-CT (17%). Sixty-three percent of all hospital deaths occurred during the first hospitalization with the majority occurring within the first two weeks. Overall hospital death rate during the first hospitalization was 29%, but higher in SI (39%) and non-SI (40%). Longer hospital stay in SI and non-SI patients, 30 and 21 days, respectively, was also observed, compared to 12 days overall. Mean (SD) costs of first hospitalization was $36,866 ($33,045) and $8936 ($10,340) for CT and non-CT, respectively but comparable on a per day basis. CONCLUSIONS: AML remains devastating and costly. Hospital mortality is high during the initial hospitalization, and a substantial proportion of deaths in this period occurs within the first two weeks.

PCN19
COLONSCOPY AND FLEXIBLE SIGMOIDOSCOPY: A MICROCOSTING STUDY EVALUATING DIAGNOSTIC PROCEDURAL COSTS IN AN OUTPATIENT ENDOSCOPY CLINIC
Sambrook JC1, Chui W1, Wang H1, Levy AR1, Enns RA2
1Oxford Outcomes Ltd, Vancouver, BC, Canada, 2St. Paul's Hospital, Vancouver, BC, Canada
OBJECTIVES: With availability of several colorectal cancer screening tools, the cost-effectiveness of population-based screening programmes is of interest. The goal of this study was to estimate the per-procedure cost of conventional colonoscopy (COL) and flexible sigmoidoscopy (SIG) in an outpatient endoscopy clinic. METHODS: An activity based costing approach was carried out using time-and-motion techniques on 104 COL and 48 SIG procedures performed in St. Paul's Hospital (SPH) between July and October 2004. Observation began with patient registration in the clinic and ended with patient discharge. Direct costs, including nursing and physician time, supplies and medications, were estimated. Indirect costs included physician and pathology fees, scope repair and cleaning expenses. Hospital overhead costs were determined through SPH finance department. Total cost was calculated as the sum of direct, indirect and overhead costs. Student's t-tests were performed to determine any significant differences (P < 0.10) of mean total cost between groups derived from baseline variables. Linear regression analysis of cost was also conducted. All costs are reported in 2004 Canadian dollars. RESULTS: Mean age of patients was 56 (22; 88) years for COL and 51 (17; 90) years for SIG. Mean total time was 189 (106; 317) minutes for COL and 53 (14; 111) minutes for SIG. Mean procedure time for COL and SIG was 34 (18; 61) minutes and 14 (7; 35) minutes, respectively. Total cost was $522 ($360; $679) for COL and $176 ($105; $287) for SIG. Physician and pathology fees accounted for 61% of total cost for COL and 58% for SIG. Number of biopsies and total time have significant predictive power on total cost for both procedures. Sex and number of polypectomies are