conducted to test the robustness of the model. **RESULTS:** The base-case ICER was $540k/QALY for abiraterone, $585k/QALY for sipuleucel-T, and $121k/QALY for prednisone. The base-case ICER was $388k/QALY for abiraterone, $647k/QALY for sipuleucel-T. Prednisone dominates both abiraterone and sipuleucel-T in terms of NMb at WTP thresholds of <$400k. At WTP thresholds of <$275k, sipuleucel-T dominates 95% of the time and abiraterone 50% of the time at a WTP <$270k. **CONCLUSIONS:** Neither abiraterone nor sipuleucel-T was found to be cost-effective compared to prednisone in the treatment of asymptomatic, pre-docetaxel mCRPC.

**PCN88**

A NOVEL COLORECTAL CANCER MODEL WITH SESSILE SERRATED ADENOMA PATHWAY TO EVALUATE THE COST-EFFECTIVENESS OF VARIOUS SCREENING STRATEGIES

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**OBJECTIVES:** Sessile serrated adenoma (SSA) was recently recognized as a separate pathway that accounts for 10-35% of colorectal cancers (CRCs). Current CRC screening tests exhibit inferior performance detecting SSAs as compared to other lesion types. Most existing CRC models do not include the SSA pathway; thus, the cost-effectiveness of CRC screening in the face of inferior SSA detection remains uncertain. We developed a novel CRC model that incorporates the SSA pathway to evaluate the cost-effectiveness of various screening strategies. **METHODS:** We modeled a population of 150,000 individuals aged 50-75 that were representative of the general US population. We investigated several CRC screening strategies within this cohort: colonoscopy every ten years (Q0), fecal immunochemical testing (FIT) every one, two, or three years (Q1, Q2, Q3), and a hybrid strategy of colonoscopy every ten years with FIT one, two, or three years after negative colonoscopy (Q10/FIT 1, COLO/FIT 2, COLO/FIT 3). The primary outcomes were all-cause mortality and colorectal cancer incidence, and adjusted life-year (QALY), and incremental cost-effectiveness ratio (ICER) per QALY. We assumed full screening compliance. All economic outcomes were discounted 3%. **RESULTS:** All screening strategies were cost saving compared to no screening. The hybrid strategy reduced cancer incidence the most (59% compared to no screening) and gained the most QALYs compared to no screening (15,200 QALYs for every 100,000 people). Compared with the standard Q0 colonoscopy strategy, COLO/FIT hybrid strategies produced ICERs of approximately $3,300 per QALY. **CONCLUSIONS:** Despite the comparatively poor performance of colonoscopy and FIT in detecting SSAs, our simulation results suggested that CRC screening would save costs and increase QALYs. Hybrid screening strategies with colonoscopy and FIT were cost-effective compared to screening with colonoscopy alone.

**PCN89**

COST-EFFECTIVENESS ANALYSIS OF BENDAMUSTINE-RITUXIMAB TREATMENT COMPARED WITH FLUDARABINE-RITUXIMAB TREATMENT, IN PATIENTS WITH INDOLENT NON-HODGKIN'S LYMPHOMA IN PANAMA

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**OBJECTIVES:** To assess the cost-effectiveness of Bendamustine-Rituximab (BR) compared with Fludarabine-Rituximab (FR) in the first-line treatment of Indolent Non-Hodgkin’s Lymphoma (INHL) that have progressed during or within six months of treatment with Rituximab or a Rituximab-containing Regimen in Panama. **METHODS:** A three-state Markov cohort simulation Markov Model (progression-free survival, death) developed, based on the time at a WTP >$100,000. **CONCLUSIONS:** Although current treatments (all-trans retinoic acid (ATRA), anthracyclines, including idarubicin, IDA, and conventional chemotherapy) are associated with high remission rates and cytototoxic adverse effects, they do not alter the natural history of the disease. We compared BR vs. FR in a societal perspective, the economic impact of arsine trioxide (ATO) + ATRA compared to ATRA + IDA in the treatment of newly diagnosed APL. METHODS: The cost-effectiveness of ATO + ATRA compared to ATRA + IDA in the treatment of newly diagnosed APL. **RESULTS:** The cost-effectiveness of ATO + ATRA compared to ATRA + IDA in the treatment of newly diagnosed APL was assessed over a lifetime horizon using a time-dependent Markov model. The model comprises four health states: complete remission, treatment failure, disease relapse, post-failure and death. The length of each Markov cycle was one month for the first 48 months and one year thereafter. All patients started in the complete remission state and could move to other health states thereafter, according to the respective efficacy of each treatment. The model also took into account the incidence of adverse events reported in a head-to-head trial. Utility or disutility values associated with each health state and adverse events were estimated as the number of QALYs associated with each treatment. Analyses were conducted from both a Canadian Ministry of Health (MoH) and a societal perspective. **RESULTS:** Compared with ATRA + IDA, ATRA + ATO is associated with ICERs of $84,092/QALY and $80,946/QALY, from a MoH and societal perspective respectively. For patients with APL, no cost-effectiveness analysis indicated that the ICER remains below $100,000 in 99.82% and 99.98% of the simulations from a MoH and a societal perspective respectively. **CONCLUSIONS:** This economic evaluation suggests that ATRA + ATO can be considered a cost-effective option for the first-line treatment of newly diagnosed APL patients.

**PCN92**

PARTIALLY COVERED SELF-EXPANDABLE METAL STENTS ARE MORE COST-EFFECTIVE WHEN COMPARED TO PLASTIC STENTS FOR PATIENTS WITH DISTAL MALIGNANT BILARY OBSTRUCTION

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**OBJECTIVES:** Partially covered self expandable metal stents (SEMS) and polyethylene terephthalate stents (PES) are commonly used for distal malignant biliary obstruction. SEMS are more efficacious yet expensive than PES. The cost-effectiveness of both stents using contemporary estimates was assessed. METHODS: A decision tree comparing initial palliative placement of PES versus SEMS was constructed for patients with distal malignant biliary obstruction requiring palliation with one-year follow-up. Patients underwent an endoscopic retrograde cholangiopancreatography (ERCP) to insert the initial stent, and were followed by a gastroenterologist every 3 months. If the insertion failed, a percutaneous transhepatic cholangiogram was performed. If stent occlusion occurred, a PES was then inserted at repeat ERCP, either in an outpatient setting, or after admission to hospital if cholangitis was present. Effectiveness was expressed as a log-odds of stent failure measured in US dollars. Probabilities were derived from a recent published randomized clinical trial. **RESULTS:** A PES-first strategy was dominated by a SEMS-first approach. The ICER was $6,541/QALY. The ICER for SEMS and $19,054 USD for initial PES, associated with relative effectiveness probabilities of 65.6% and 13.9% (likelihood of experiencing no occlusion over 12 months). Sensitivity analyses confirm the robustness of these results. They are however limited by the randomized trial when stent probabilities were derived, with regards to sample size and generalizability. **CONCLUSIONS:** At the time of initial endoscopic drainage for patients with malignant biliary obstruction undergoing palliative stenting, an initial SEMS approach is both more effective and less costly than a PES-first strategy, regardless of anticipated survival or cost setting.