care health plan; patients were followed until death, disenrollment from the health plan; patients were followed until death, or end of study period, whichever occurred first. CONCLUSIONS: Although costs were initially similar for CRPC patients who died compared to patients alive at study end, patients who died had significantly larger increases in costs over the 2-year period, with the sharpest increase in the last year of life with mean costs roughly tripling (from $15,185 to $44,203). For patients who did not die, mean total costs increased by $1,313 in each subsequent year, from $6,809 to $13,170 at the end of follow-up.

RESULTS: 260 CRPC patients died, with 2304 patients alive at the end of the study (mean age 73.99 vs. 72.63 years, p < 0.05). 2 years prior to death/ end of follow-up, comorbidity scores were similar and mean total costs per 4-month period were not significantly different for patients who died vs. those alive ($8,292 vs. $6,809, p = 0.060). Health care costs increased prior to death, with the sharpest increase in the last 4-months of life with mean costs roughly tripling ($15,185 to $44,203). For patients who did not die, mean total costs increased by $1,313 in each subsequent year, from $6,809 to $13,170 at the end of follow-up.

CONCLUSIONS: Although costs were initially similar for CRPC patients who died compared to patients alive at study end, patients who died had significantly larger increases in costs over the 2-year period, with the sharpest increase in the last year prior to death.

PCN45

HEALTH CARE UTILIZATION AND COSTS OF RESECTED SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK (SCCHN) IN AN INCIDENT COHORT OF PATIENTS IN THE UNITED KINGDOM

Kim F1, Amorcon M2, Högberg D3, Kasteng F4

1Department, Stockholm, Sweden; 2Gaziantep University, Coligerville, PA, USA

OBJECTIVES: 7,538 new cases of SCCHN were diagnosed in 2006 and 2,594 deaths reported in 2007 in the UK. For patients with resectable SCCHN surgical resection followed by postoperative radiation therapy remains a common treatment approach across the globe. The impact of control chemotherapy is also an important treatment component. METHODS: This retrospective analysis was based on inpatient and outpatient records extracted from Hospital Episode Statistic database. SCCHN patients with resection of oral cavity, pharynx or larynx between 2003-07-01 and 2008-12-31 (for at least 5 years) from the surgery date. RESULTS: There were 38,460 patients diagnosed with SCCHN in the dataset, 11,403 patients met the inclusion criteria for the study. Mean age was 63.2 years and 69.8% were male. Mean length of follow-up was 31.0 months. In the first year, mean length of hospitalization was 21.4 days and mean number of outpatient visits was 4.2. Mean number of reconstructive and secondary surgeries per patient was 0.32 and 0.14, respectively in the first year. Mean number of radiotherapy and chemotherapy sessions per patient was both 0.45 in the first year. Total costs of post-surgery healthcare utilization in the patient cohort was €240 4 million annually for 5 years with 90% (€225.5 million) occurring within the first year. Mean cost was €19,778 for the first year and €1477, €847, €653 and €455 for years 2-5. Inpatient care costs accounted for 96% of total costs with hospitalization contributing to 85% of these costs. CONCLUSIONS: Given limited data in the HES, radiotherapy and chemotherapy utilization and costs in the outpatient setting are likely to be underestimated. However, results still indicate that treatment of resected SCCHN in the UK is associated with significant healthcare utilization and costs. This suggests the need for new therapies that could improve outcomes and reduce the economic burden.

PCN41

FINANCIAL BURDEN AMONG PATIENTS WITH MAJOR CANCERS: FINDINGS FROM THE UNITED STATES MEDICAL EXPENDITURE PANEL SURVEY, 1996-2007

Lang E, Huang H, Rodriguez L, Menzin J

PHARMO Institute, Utrecht, The Netherlands; 2Aymen, Inc., Thousand Oaks, CA, USA

OBJECTIVES: Out-of-pocket (OOP) medical expenditures of families may pose a financial burden, particularly to the seriously ill. The objective of this study was to study the medical expenditure of insured patients with cancer and its influence factors, to analyze the utilization of pharmaceuticals, treatment-seeking behavior and the relationship between the medical expenditure and payment patterns of medical insurance. METHODS: This study involved 5351 cancer cases in 1 municipality (Beijing, Shanghai, Chongqing) and 5 province-capital cities (Shenyang, Fuzhou, Jinan, Zhengzhou, Xining). The actual claim data of their medical expenditure and medical care utilization in 2008 were collected. Descriptive analysis and multivariate linear regression analysis were applied. RESULTS: 1) Outpatients' medical expenditure per head is lower than that under fee-for-service. 2) Multivariate regression analysis showed that the main influence factors of inpatient medical expenditure include medical insurance payment pattern, hospital level, category of cancers, gender, length of stay in hospital, and medical insurance type. When all factors other than payment pattern were set to be control parameters, inpatient's annual medical expenditure per head under flat rate payment was US$548 lower than that under fee-for-service. CONCLUSIONS: Medical expenditure causes heavy burden for cancer patients and the BMI fund. Flat rate medical expenditure has proved to be more effective in expenditure control compared with fee-for-service. To keep the fund safe and running effectively, it is necessary to adjust present payment patterns and set rational payment standard to encourage medical care providers to control the expenditure actively.

PCN46

HEALTH CARE EXPENDITURES, DISABILITY DAYS, AND RESOURCE UTILIZATION ASSOCIATED WITH CANCER IN EMPLOYER SETTINGS IN THE UNITED STATES

Tang D1, Alberts DS1, Nevinia R2, Sullivan S3, Skrepnek GH1

1The University of Arizona, Tucson, AZ, USA; 2Institute for Health and Productivity Management, Scottsdale, AZ, USA

OBJECTIVE: To assess healthcare expenditures, disability days, and resource utilization associated with cancer in employer settings in the United States. METHODS: This retrospective database analysis utilized 2007 Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey (MEPS) public-use data. Inclusion criteria included age ≥ 18 years, any diagnosis of malignant neoplasms (including both new cases and hospital outpatient treatments), and employed patients. RESULTS: 3.86 million employed adults in the US had new or continued cases of cancer in 2007, averaging 54.0 (SE 1.8) disability days, employer size, perceived health status, secondary malignancies, and the BMI fund. Flat rate medical expenditure has proved to be more effective in expenditure control compared with fee-for-service. To keep the fund safe and running effectively, it is necessary to adjust present payment patterns and set rational payment standard to encourage medical care providers to control the expenditure actively.

PCN42

COSTS OF HOSPITAL EVENTS IN PATIENTS WITH METASTATIC COLORECTAL CANCER

Overbeek J1, Zhao Z2, van Herk-Sukel MP2, Barber ML2, Gao G3, Herings RMC1

1PHARMO Institute, Utrecht, The Netherlands; 2Amgen, Inc., Thousand Oaks, CA, USA

OBJECTIVES: Monoclonal antibodies improve treatment outcomes in patients with metastatic colorectal cancer (mCRC), they have distinct and known safety profiles that may be associated with toxicities requiring hospitalization, which likely further impact cost of patient care. The objective of this study was to determine hospital care costs from the global mCRC treatment system, including drug dispensing and hospitalization records of approximately 3.2 million residents in The Netherlands, all patients with a primary or secondary hospital discharge code for CRC and distant metastases between 2000 and 2008 were included. The first discharge diagnosis for metastases served as the index date. Patients were followed from index date until end of data collection, death, or end of study period, whichever occurred first. Main outcomes for each identified event were length of stay (days) and costs per hospital admission. So all results are descriptive.RESULTS: A total of 3,764 pa- tients with mCRC identified, 271 hospital events occurred during a median follow-up of 24 months. The longest mean (± SD) lengths of stay per hospital admission were for stroke (16 ± 33 days) and arterial thromboembolism (AT) (14 ± 21 days) followed by wound healing complications (WHC), acute myocardial infarc- tion (AMI), congestive heart failure (CHF), and neutropenia (all 9 days with SD 5 to 15). Highest mean (± SD) costs per admission were observed for stroke (€31,280, AT €13,300 ± €18,800), and WHC (€10,800 ± €20,500), followed by AMI (€9,000 ± €7,500), neutropenia (€7,900 ± €4,400), and CHF (€7,700 ± €6,300). Lowest mean (± SD) costs were for dermatological therapy (€5,400 ± €5,200) and hypertension (€4,100 ± €2,800). CONCLUSIONS: Inpatient costs for events in patients with mCRC are considerable and vary greatly. Such data are valuable to the pharmacoeconomic evaluations of newer treatments in patients with mCRC.