using electronic hospital records. Survival was assessed using the Kaplan-Meier estimate. Recurrence patterns were investigated by type of first recurrence and time-to-recurrence. A multivariate cox regression was used to analyze whether time-to-recurrence was associated with gender, age, and tumor thickness. Emigrated patients (n=10) and patients with an unknown recurrence status (n=144) were excluded. 3177 patients, 1516 of whom had experienced disease progression (median follow-up=5.5 years). Patients who developed a recurrence had a lower survival compared to patients who did not develop a recurrence (median OS: 9.4 months vs. 2.8 years, p<0.001). The most frequent type of first recurrence was lymphatic (36.9%), followed by distant (22.5%), local (21.6%) and intramyellic (9.9%), respectively. The median time-to-recurrence has not yet been reached, however, in case of a recurrence, the median time-to-recurrence was 2.5 years (minimum: 0.01 years, maximum: 9.8 years). The time-to-recurrence was not statistically significantly associated with gender (HR=0.81, p=0.29), age (HR=1.01, p=0.38) and tumor thickness (HR=0.78, p=0.07). CONCLUSIONS: The long-term surveillance of stage IV prostate cancer patients is of utmost importance, because survival subsequent to recurrence is much lower than expected. The risk of developing a recurrence was substantial; however, the time-to-recurrence was not associated with gender, age and tumor thickness.

PCN30

EPIDEMIOLOGY OF PATIENTS WITH METASTATIC CAstrate Resistant Prostate CANcer in EUROPE AND AUSTRALIA

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OBJECTIVES: The objective of this study was to evaluate both the incidence of metastatic Castrate Resistant Prostate Cancer (mCRPC) and the number of mCRPC patients who receive specific mCRPC treatments (mCRPCTT): chemotherapy and second generation Hormone Therapies (ADT manipulations were not included). METHODS: This study was conducted in 8 European countries and Australia. The incidence of mCRPC patients was assessed using several sources: national cancer registries, national treatment registries, a large database of patients receiving mCRPCTT. The characteristics and frequency of mCRPC patients were selected from the Netherlands Cancer Registry (n=3292 oncologists, 76 onco-radiotherapists and 357 urologists reported information about 4171 prostate cancer patients). Of these, 2401 had metastatic castrate resistant disease. Patient characteristics and treatments received were assessed and reported separately by country. RESULTS: Across all 9 countries, 76,200 new patients were diagnosed mCRPC over the past year. Of these patients, 35% (26,400 patients) went to supportive care without receiving any mCRPC TT while 65% (49,800 patients) received a 1L mCRPCTT. Prior to receiving any 1L mCRPCTT, 43% of patients had ADT manipulations during a short transitional period (median duration =1 month). Of the 49,800 patients who received a 1L mCRPCTT, 59% (29,250) went to a 2L mCRPCTT, 15% decreased during or just after the 1L TT and 26% went on to receive supportive care only. The remaining 10% were still alive and received no treatment. Of these patients, 63% were treated with chemotherapy and 37% with hormone therapy for a 3L mCRPCTT. CONCLUSIONS: Our methodology enabled us to assess incidence figures and the volume of mCRPC patients who receive specific mCRPCTT: over one-third of mCRPC patients did not receive any mCRPCTT. Among the 65% who received a 1L TT, 59% receive a 2L mCRPCTT.

PCN31

COMPARISON OF EPIDEMIOLOGY AND DRUG TREATMENT IN HER2 NEGATIVE METASTATIC BREAST CANCER (MBC) IN EUS

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OBJECTIVES: Explore differences/similarities in epidemiology and drug treatment of metastatic breast cancer (MBC) in EUS. METHODS: All data was derived from the Kantar Health CancerMPact database, sources for which include country specific treatment surveys, databases of patients treated with chemotherapy or second generation Hormone Therapies (ADT manipulations were not included). To forecast the AM population using historical rate data (1991-2012) and other population parameters including incidence rate annual percent change, stage at diagnosis, rates of disease progression and survival obtained through a comprehensive literature review and hand-search of cancer registry websites. Analysis of a cross-sectional sample (Ipsos Global Oncology Monitor) of 1,297 patients in the EU-5 was used to address any clinical data gaps. The model was validated by comparing projected 5-year prevalence rates to GLOBOCAN 2012 estimates. RESULTS: The model-projected number (rounded to nearest 100) of incident melanoma cases for 2014 was: Germany=23,100; UK=18,900; France=12,400; Italy=12,000; Spain=5,800. Of incident cases, 11.3%-13.0% were treatment eligible AM. Incidence rates increases of 1-5% over the projection period were applied. Analysis of IFOS50 data and review of the literature showed BRAF and FD-11 prevalence rates of 45.4%-56.2% and 15.9%-16.7%, in AM patients, respectively. Literature-derived, brain metastasis prevalence ranged from 15.9%-36.5% in Stage IV patients. Considering case progression, resection and adjuvant treatment rates, the forecasted number of AM patients eligible for 1st and 2nd line treatment in 2018 is, respectively: Germany=3,700 and 1,700, UK=1,100 and 1,400, France=1,900 and 500, Italy=1,800 and 1,000, Spain=600 and 200. CONCLUSIONS: While melanoma incidence is projected to increase over the next 5 years the majority of incident cases will be diagnosed in earlier disease stages. Under these assumptions, the largest proportion of the incident melanoma population that is AM patients initiating treatment is expected to be 12% in 2018, a slight decline from 2014.

PCN34

A VALIDATED PREDICTION MODEL AND NOMOGRAM FOR RISK OF RECURRENCE IN EARLY BREAST CANCER PATIENTS

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OBJECTIVES: The objective of this study is to develop and validate a conditional logistic regression model for the prediction of locoregional recurrence (LRB) of breast cancer. To make a translation to clinical practice a web-based nomogram was made. METHODS: Women first diagnosed with early breast cancer (without distant metastasis) requiring breast or skin surgery 2003-2006 were selected from the Netherlands Cancer Registry (n=39,929). Risk factors for LRB within five year of the primary treatment were determined using logistic regression. Risks were determined per year, conditional on not being diagnosed with recurrence in the previous year. The presence of interaction and collinearity in the nomogram was assessed, as well as the discrimination by means of the area under the ROC curve and calibration by the Hosmer-Lemeshow goodness-of-fit test in discrimination. Prognosed to be at high risk 12% of patients, the selection of Dutch hospitals was used for external validation of the performance of the nomogram (n=13,792). RESULTS: The final model included the variables grade, multifocality, nodal involvement, primary tumour type, size of surgery, and whether patients were treated with radio-, chemo- or hormone therapy. The modelling group showed an area under the ROC curve of 0.82, 0.74, 0.67 and 0.70 and 0.60 respectively per subsequent year after primary treatment. The calibration was sufficient. The effects in the validation group were similar and the estimates in the validation group did not differ significantly from the modelling group. CONCLUSIONS: This validated nomogram can be used as an instrument to aid clinical decision-making and to identify patients with a high risk of breast cancer recurrence who might benefit from a more intensive follow-up after breast cancer.