blets (n=529, 72%), particularly carboplatin-paclitaxel (n=285, 39%), accounted for most off-label GL concordant care. NCCN GL recommendations for carboplatin-based doublets are supported by phase III clinical trials. **CONCLUSIONS:** The majority of advanced NSCLC patients received first-line therapy that was concordant with NCCN GL recommendations but was outside the FDA labeled indication. These GL concordant, off-label uses are supported by high-level evidence including phase III clinical trials.

PCN122

MELODY BRAZIL: CHEMOTHERAPY CHOICES FOR PATIENTS WITH METASTATIC MELANOMA IN THE PUBLIC HEALTH CARE SYSTEM (SUS)

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OBJECTIVES: The aim of this study was to assess treatment choices for patients diagnosed with metastatic melanoma in SUS settings. **METHODS:** The patient flow pathway was determined by patients receiving systemic therapy for diagnosed melanoma stage IV (ICD-C43) from a government administrative database (SIA/DATASUS). Patients ineligible for upfront therapy could not be captured. Systemic therapy at each line treatment and time to progression data from Jan/2008 to Jun/2010 was collected. Patients were classified as active (analyzed during all period), lost during follow-up (unknown reason) and dead. **RESULTS:** Data from 1,049 patients was analyzed, 48.1% lost follow up and 8.3% had documented death. By the end of the study, 43.6% were still active. The average follow-up time was 8.6 months. All patients received at least one line of systemic therapy. First line therapy (FLT), 49.7% received dacarbazine and 29.1% interferon. By Jun/2010, 175 (16.7%) patients received second line therapy (SLT), 42.5% lost follow-up, 6.6% died and 34.2% remained in FLT. The most common SLT regimens were dacarbazine (28.0%), interferon (17.7%) and paclitaxel (14.9%) and the average time to switch from FLT to SLT was 5.5 months. During SLT, 28.0% lost follow-up, 7.4% died and 47.4% of patient remained active till jun/2010. Thirty patients (2.9%) received a third line therapy (TLT), with an average time from the beginning of SLT to TLT of 5.2 months. Paclitaxel (23.3%) and interferon (20.0%) were the most commonly used regimens. **CONCLUSIONS:** For metastatic melanoma patients in the SUS, the main chemotherapy regimens in FLT and SLT were dacarbazine and interferon. Paclitaxel was the most common TLT agent along with interferon.

PCN123

A SYSTEMATIC REVIEW OF TREATMENT GUIDELINES FOR METASTATIC COLORECTAL CANCER

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OBJECTIVES: The objective of this systematic review was to identify treatment guidelines for metastatic colorectal cancer (mCRC) and to assess guideline recommendations. **METHODS:** Publications were identified through electronic searches of MEDLINE, MEDLINE In Process, EMBASE and the Cochrane Library; through manual searches of the reference lists of relevant articles; and by searching websites on the Internet. The MEDLINE and EMBASE searches were limited to articles published in English, whereas the Cochrane library search had no language restrictions. **RESULTS:** A total of 1,633 citations/abstracts were identified from electronic database searches. Of these, 91 underwent full-paper review and 32 were included in the final analysis. In addition, 25 articles were identified from manual and website searches, giving a total of 57 guidelines. The guidelines were published between 1996 and 2010, with the majority published between 2004 and 2010. The country publishing the most guidelines was the USA (12), followed by the UK (10), Canada (8), France (8), Germany (3), Australia (2), Spain (2) and Italy (1). In addition, eight European and three International guidelines were identified. As monoclonal antibody therapy for mCRC was not introduced until 2004, no firm recommendations for monoclonal antibody therapy were made in guidelines published between 2004 and 2006. Recommendations for monoclonal antibody therapy first appeared in 2007 and evolved as more data became available. The most recent international, European, and US guidelines recommended combination chemotherapy with a monoclonal antibody for the first-line treatment of mCRC, while second-line treatment varied depending on the first-line regimen used. Cetuximab and panitumumab were recommended in patients with wild-type *KRAS* mCRC. **CONCLUSIONS:** The findings from this systematic review indicate that these recent treatment guidelines have recognized the role of monoclonal antibodies in the management of mCRC; and timely treatment guideline updates are necessary to reflect the most recently available data.

PCN124

CLINICAL AND DEMOGRAPHIC CHARACTERISTICS OF CHRONIC MYELOGENOUS LEUKEMIA PATIENTS TREATED AT PUBLIC ONCOLOGY CLINICS IN SÃO PAULO, BRAZIL

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OBJECTIVES: This study aims to describe clinical and demographic characteristics of chronic myelogenous leukemia (CML) patients receiving therapy on public cancer centers in São Paulo state, Brazil. **METHODS:** Cross-sectional analysis of São Paulo state CML-related pharmacy claims as reported in the Ambulatory Information System database. Patients were included if they have at least one claim with CML ICD-10 code during April 2010. Repeated records were excluded using identification code, age, sex, and diagnosis date as compatibility criteria. Kruskal-Wallis test was used to compare clinical and demographical variables and cost of treatment among patients receiving each protocol. **RESULTS:** 1,326 patients were identified as CML patients, 53.32% male with a mean age of 51.08 years (SD=17.07). The mean disease duration was 2.38 years (SD=3.02; range 0-21.27 years) for those patients for whom data was available (n=1,307). The proportion of patients receiving tyrosine kinase inhibitors (TKI) was 85.67% (imatinib=74.06%; dasatinib=8.82%; nilotinib=2.79%). Other reported therapeutic strategies were: hydroxyurea (7.24%), non specified oral cancer therapy (3.17%), chemotherapy protocols (0.75%), interferon (0.60%), and others (2.56%). Median age was significantly ($p<0.05$) different among hydroxyurea-treated patients (67 years), others (46 years), and chemotherapy (15 years) as compared to TKI, interferon and non specified oral drugs. Higher median disease duration was observed for nilotinib-treated patients (4.74 years), interferon (2.73), and dasatinib (2.31). The median disease duration of imatinib treated patients was 0.96 years ($p<0.05$ vs. all comparisons except hydroxyurea). The median cost of treatment ranged from 80 BRL to 6,678 BRL for hydroxyurea and nilotinib ($p<0.05$). **CONCLUSIONS:** Among this sample, the most frequent therapeutic approach for CML patients was TKI, particularly imatinib, but second-generation TKIs have also been prescribed for patients with significantly longer disease duration, which is consistent with current guidelines that recommend that they should be prescribed in later lines.

PCN125

MELODY BRASIL: TREATMENT PATTERNS AND ASSOCIATED COSTS OF METASTATIC MELANOMA PATIENTS IN THE BRAZILIAN PUBLIC HEALTH SYSTEM (SUS)

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OBJECTIVES: The aim of this study is to document treatment patterns of care and associated costs of metastatic melanoma in Brazil from the Public Health System (SUS) Perspective. **METHODS:** A review of a government administrative claims database (Outpatient Information System - SIA/DATASUS) was conducted from Jan 2008 to June 2010. Patients receiving radiotherapy and/or systemic therapy for diagnosed melanoma (International Code of Disease (ICD-10) C43) stage IV were included in the analysis. Information on type of treatment (chemotherapy, radiotherapy), chemotherapy scheme, length of treatment and associated costs (in 2010 USD) were collected. **RESULTS:** 2,488 patients met the inclusion criteria, 54.3% male with an average age (SD) of 56.3 (15.0) years. 42.2% lived in the Southeast region and 38.5% in the South. Less than 40% of the cases had the primary cancer site reported. Dacarbazine was the most widely used agent (administered to 1,700 patients), followed by interferon (1,059 patients) and cisplatin (435 patients). Dacarbazine monotherapy was the most commonly administered chemotherapy regimen (37.9% of the patients; average length of treatment of 3.1 months), followed by interferon monotherapy (30.1% of the patients; average length of treatment of 4.6 months) and paclitaxel monotherapy (3.5% of the patients; average length of treatment of 2.8 months). Overall cost of care expenses were USD16,238,160, 99% of the cost was attributable to chemotherapy (USD16,024,555). Total expenses in 2009 (USD6,667,687) increased 12% compared to 2008; interferon monotherapy accounted for 38.5% (USD6,245,742) of expenses, and dacarbazine monotherapy accounted for 32.2% (USD5,230,315). **CONCLUSIONS:** Patients with advanced melanoma, in the Brazilian Public Healthcare System (SUS), nearly all receive systemic therapy. Dacarbazine as single agent is the most common regimen, followed by interferon with a significant financial impact to the Public Healthcare System, totalizing USD16,238,160 in the last two and a half years.

Cancer – Research on Methods

PCN126

OVERVIEW OF PRIMARY ENDPOINTS, PROGRESSION-FREE SURVIVAL (PFS) AND OVERALL SURVIVAL (OS) FOR NON-SMALL CELL LUNG CANCER (NSCLC): THEIR VALUE IN TREATMENT DECISIONS AND PATIENT CARE

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OBJECTIVES: NSCLC (accounting for 80% of all cases of lung cancer) causes high morbidity and mortality. Various treatment lines are available for NSCLC, and there are ongoing discussions on the most appropriate measure of treatment efficacy for reimbursement decisions. We examined the use of these endpoints in NSCLC from a payers' perspective. **METHODS:** Targeted searches were conducted in MEDLINE® and the Cochrane Database of Reviews, using clinical and health economic-related key words and limited from 2000 to 2010. **RESULTS:** OS can be measured easily and accurately in terms of both event and time and is the endpoint preferred by regulatory bodies including the FDA and EMA. Over the last 10 years the benchmark OS for first-line treatment of NSCLC has risen and it is increasingly difficult to demonstrate significant OS benefit, as the efficacy (clinical trial results) of treatments has improved. Demonstrating improvements in OS over best supportive care is less challenging than against an active comparator. Adequate powering of studies to demonstrate OS benefit is vital but requires large study populations. Demonstrating a significant PFS benefit is also challenging, requiring frequent assessments, precise event definition and exact determination of the time of event. Nevertheless, PFS provides a well-accepted alternative endpoint to OS as