

(89%). Predictors of second treatment after biochemical failure for RP included PSA at diagnosis ($p < .0001$), T stage ($p = .0062$) and biopsy Gleason score ($p = .0109$). Patients with a PSA > 20 , T3 disease and Gleason 8–10 had a 4.5 fold, 3.6 fold and 3.5 fold increased risk of second treatment as compared to patients with a PSA < 4 , T1 disease, and Gleason 2–6, respectively. For XRT, predictors of second treatment included biopsy Gleason score ($p < .0001$) and PSA at diagnosis ($p = .0057$). Patients with Gleason 8–10 and PSA > 20 had a 5.4 fold and 6.5 fold increased risk of second treatment as compared to patients with Gleason 2–6 and PSA < 4 , respectively. **CONCLUSION:** Second treatment timing and type differs for RP and XRT patients who fail biochemically. Pretreatment clinical factors can be used to determine which patients are at highest risk for second treatment. This has implications for initial treatment efficacy.

PCN2

DARBEPOETIN ALFA 200 MCG EVERY 2 WEEKS (Q2W) AND EPOETIN ALFA 40,000 UNITS EVERY WEEK (QW) IN CHEMOTHERAPY-INDUCED ANEMIA PATIENTS RESULT IN SIMILAR INITIAL HEMOGLOBIN OUTCOMES

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Darbepoetin alfa (Aranesp®, DA), a unique erythropoietic molecule with 3-fold longer half-life than epoetin alfa (EPO), is indicated for treatment of chemotherapy-induced anemia (CIA). **OBJECTIVE:** To determine the most common initial dosing regimens for DA and EPO in clinical practice and evaluate their effectiveness after four weeks of therapy. **METHODS:** In order to determine which initial regimens are most commonly used in practice as well as their effectiveness, we conducted a chart review within Tennessee Oncology. Tennessee Oncology, a major provider of cancer care in the Nashville area, has collected extensive data on EPO and DA use as part of their quality assurance process. DA patients switched from EPO were not eligible for the analysis. Mean hemoglobin changes were not adjusted for transfusions. **RESULTS:** Of 408 patients treated with an erythropoietic agent, 196 received DA and 212 received EPO. The majority of EPO patients (86.3%) had an initial dosing schedule of 40,000 U QW (EPO40KQW). The majority of DA patients received a fixed dose. Of 196 DA patients, 97 (49.5%) received 100 mcg QW (DA100QW) and 70 (35.7%) received 200 mcg Q2W (DA200Q2W). Hemoglobin (hgb) values were collected at baseline and beginning of week 5. Mean baseline hgb (g/dL) [95% CL] for the DA100QW, DA200Q2W and EPO40KQW groups were 10.2 [±0.15], 9.9 [±0.18], and 9.7 [±0.14], respectively. Mean changes in hgb (g/dL) [95%CL] after 4 weeks of therapy for the DA100QW, DA200Q2W, and EPO40KQW group were 0.9 [±0.24], 1.1 [±0.29], and 0.8 [±0.22], respectively. The median for each group was very similar to the corresponding mean. **CONCLU-**

SIONS: These results establish that 200mcg Q2W DA maintained dose efficiency when compared to 100mcg QW and was at least as effective as 40,000 U QW of EPO after 4 weeks therapy in patients with CIA.

PCN3

PERFORMANCE OF THE MC-PEEK-SCORE FOR SURGICAL OUTCOME

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OBJECTIVES: In the era of restricted financial resources for health care different strategies are developed to optimize patient outcome, but all of them need a valid outcome measurement. One of such concepts for surgical patients is the McPeek-Score which was evaluated in three trials. **METHODS:** The discontinuous McPeek-Score gives 1 point for a patient who died in the operation theatre, 2 for one who died in hospital postoperatively, 4 or 5 for a patient discharged alive with great or moderate amount of ICU care, 7, 8 or 9 points for a routine recovery with long, average or short postoperative hospitalization, respectively. The postoperative recovery index of McPeek was used in 699 patients in 3 trials. Patients in trial 1 had elective, colorectal cancer surgery, in trial 2 oncological, endocrine, and vascular surgery, and in trial 3 cholecystectomy. Reliability, validity, sensitivity and practicability of the McPeek-Score were investigated. **RESULTS:** The score is reliable, because the results were reproduced in three different hospitals and by different investigators in one trial. Score points were distributed over all classes with a maximum of 7–9 points. Validity of the score was demonstrated by correlation to complication rate, ASA-Score, and age with correlation coefficients of 0.6–0.7 in the 3 trials: The score measures what it claims to measure. Sensitivity of the McPeek-Score was shown in trial 2 by differences between tumour- and non-tumour patients (8 vs. 7 points, $p < 0.001$, chi-square-test) and in trial 3 between emergency- and non-emergency patients (9 vs. 7 points, $p < 0.001$). The score is very practicable, because the surgeon needs only a few minutes to get the score value, it does not interfere with his routine tasks. **CONCLUSIONS:** The McPeek-Score is well suited to assess outcome of surgical procedures. It is only applicable to major surgical situations where mortality and ICU treatment is of importance.

PCN4

ESTIMATING LIFE LOST DUE TO CANCER IN THE US—A COMPARISON OF LONGITUDINAL AND CROSS-SECTIONAL MEASURES

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