switchers who increased imatinib dose to >400 mg/day (dose escalators) were then followed until treatment discontinuation or end of eligibility. Negative binomial regression models were used to compare resource utilization associated with dose escalators vs. switchers, controlling for demographics, baseline imatinib treatment patterns, co-variables, adverse events, and resource utilization. Cox regression models were used to study hospice services and stem cell transplants during the follow-up period among patients without such prior event. RESULTS: Among CML patients who initiated on imatinib, 474 dose escalators and 175 dasatinib switchers were identified. Compared to dose escalators, switchers had significantly more frequent inpatient visits (incidence rate [IRR] = 3.37, p = .005), emergency room visits (IRR = 1.30, p = .018), and outpatient visits (IRR 1.38 p < .001). Although low in absolute rates, switchers had substantially higher risks of hospice use (hazard ratio [HR] = 14.55, p = .066) and stem cell transplant (HR = 8.71, p = .006), indicating deteriorated clinical outcomes. CONCLUSIONS: Imatinib-treated CML patients who switched to dasatinib are associated with significantly more intensive resource utilization and adverse clinical outcomes than those who escalated to higher doses. Further studies are warranted to examine the causality of the differences in resource utilization and clinical outcomes.

CANCER – Patient-Reported Outcomes Studies

PCN18 PREFERENCES IN MULTIPLE MYELOMA TREATMENT – WHAT DO PHYSICIANS THINK? Mühlbacher AC, Berndt K, Schreder CH, Nübling M

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OBJECTIVES: In the present study, physicians’ beliefs about patients’ preferences regarding the treatment of MM were explored in a direct assessment and a Discrete Choice Experiment (DCE) and were compared to the previously explored patients’ preferences. METHODS: In a preceding DCE with MM-patients, relevant attributes of an ideal MM-treatment were collected by reviewing the literature and by conducting a qualitative study with four focus groups. The attributes were analyzed in a subsequent quantitative study using both a direct measurement (16 items on a 5-point Likert-scale) and a DCE (8 pairs with 8 characteristics). In the present study, 243 physicians answered (76% male, 62% haematologist specialists, 70% with >10 MM-patients in the last 12 months) the identical questionnaire. RESULTS: Physicians rated physical quality of life (specified as “reduced mobility or good mobility”, pain, role functioning, effects and effectiveness) of treatment options (duration of effect, prolonged life expectancy and effectiveness) as most important attributes from the patients’ perspective. While the direct assessment gathers a range of important aspects, weighing particular relevant treatment attributes in a DCE is important. Physicians ranked prolonged life expectancy as most relevant and importantly more important than all other treatment attributes. Further treatment options were second most important and significant compared to breaks in therapy and physical quality of life, whereas the patients ordered these two top priorities reversely. CONCLUSIONS: Over a broad range of treatment attributes the physicians’ perceptions of preferences were very close to those of MM patients. However in the DCE, after weighing the attributes patients assigned a higher relative importance to further treatment options and “Not always think of the disease”, but less to prolonged life expectancy and self-application.

PCN19 HEALTH RELATED QUALITY OF LIFE IN THE DIFFERENT STAGES OF NON-HODGKIN LYMPHOMA IN PATIENTS ATTENDED IN THE SOCIAL SECURITY MEXICAN INSTITUTE Balderas-Peña LMA, Contreras-Hernández I, Mould-Quispe J, Garduño-Espinosa J, Morgan-Villalía G

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OBJECTIVES: The aim of this study was to document the current health related quality of life in different stages of non-Hodgkin lymphoma in patients attending in a tertiary referral center at the Social Security Mexican Institute. METHODS: We included outpatient with non-Hodgkin lymphoma, attended in a tertiary referral center since July to August 2008, with the following inclusion criteria: older than 16 years, non-Hodgkin lymphoma diagnostic, accepted were included through informed consent, were excluded patients with secondary malignant neoplasm or incomplete information. To calculate health related quality of life EORTC QLQ-C30 score validated Spanish version to Mexico was used; were evaluated global health status, functional scales (physical, role, emotional, cognitive, social) and symptom scales (fatigue, nausea and vomiting, pain, dyspnea, insomnia, appetite loss, constipation, diarrhea, financial difficulties) in scale since 0 to 100 (0 = death, 100 = perfect health). We were calculated means and range for EORTC QLQ-C30 score items; statistical differences were calculated through ANOVA test, p value ≤0.05 was considered significant. RESULTS: We studied 31 colorectal cancer patients, mean age patients was 55 ± 11.5 years old, 54% were women, 71% were married, and 38% had secondary school. The staging of this group was distributed as follow; II-4 (13%), III-2 (6%), IV-7 (23%) and NC (non-classified)-18 (57%) (without complete histopathology report). Health related quality of life mean according for all items was: II:5.7 ± 2.2, III:8 ± 6.12 and IV:6.3 ± 14 NC: 7.6 ± 19 (p = 0.17) the assumptions associated with a decreased health related quality of life associated with disease progression were emotional function (I-8.3, II-63, III-66; p = 0.05), cognitive function (I-10, II-8.3, III-50, IV-56; p = 0.06). CONCLUSIONS: We observed a decreased health related quality of life associated with late clinical stage in emotional and cognitive function.