mammography at age 40. OBJECTIVE: To develop a preliminary model to evaluate the cost-effectiveness of these guidelines, using similar assumptions and clinical trial evidence sources for the breast cancer mortality benefit as the ACS. METHODS: Interventions: Annual mammography until age 70 vs. no annual mammography. Design: Age-specific discounted lifetime costs and discounted quality-adjusted life expectancy were estimated for each intervention, and the incremental cost-effectiveness ratio (ICER) calculated. Life-expectancy estimates were generated by Markov model simulation starting from age 40. Direct costs included the management of early-stage and invasive breast cancer, and the costs of mammography and the workup of a positive result. Indirect costs accounted for the time spent getting mammograms. BC management costs with and without mammography were assumed to be the same. Time Horizon: Lifetime. Perspective: Societal. Target Population: The model was estimated in white females aged 40 and over. Data Sources: RCT Meta-analysis evidence sources used by the ACS, SEER data for BC mortality and life expectancy, NCHS life-tables data, studies of mammography performance, and quality of life/health utility studies. Sensitivity analysis was done to the discount rate, costs, sensitivity of mammography and costs of mammography. RESULTS: Base-Case Analysis: The ICER for annual mammography until age 70 was extremely high with a minimum value of $347,442/QALY at age 60. Annual mammography until age 80 was slightly more cost-effective, ranging from $424,058/QALY, $323,893/QALY and $271,773/QALY at ages 40, 55, and 70 respectively. CONCLUSIONS: Annual mammography starting from age 40 may turn out to be a very expensive policy. However, the economic model has some limitations: the mammography intervention may be associated with different BC management costs; and the data sources for BC mortality reduction with mammography have been widely disputed.

CANCER

CANCER—Quality Of Life/Patient Preferences

PCN21

SHORT-TERM PSYCHOSOCIAL COUNSELING FOR PATIENTS WITH NEWLY-DIAGNOSED PROSTATE CANCER

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OBJECTIVE: Prostate cancer can have significant physical, psychological, and social impact on patients, particularly early in the treatment course. While psychological intervention during oncologic care has been shown to improve all aspects of well-being, few studies have focused on men diagnosed with prostate cancer or have targeted the period between diagnosis and treatment. We evaluated the efficacy of an innovative, brief psychosocial counseling program delivered to men before and after prostate cancer treatment. METHODS: One hundred thirty-two men diagnosed with prostate cancer were randomly assigned to either intervention (n = 69) or control (n = 63) groups. Participants completed the Profile of Mood States (POMS), Index of Coping Responses (ICR), and scales measuring general and disease-specific HRQOL, at baseline (before treatment commenced) and at months 3 and 12. Both groups received standard medical care; and intervention participants received 2 sessions of counseling before treatment and one session 4 to 6 weeks after treatment completion. RESULTS: Intervention effects were evaluated using a mixed model analysis, adjusting for cancer treatment (radiation or surgery) and time. There were no significant differences between groups on baseline on the demographic or psychosocial measures. In the mixed model, intervention participants reported significant improvements over time on three outcomes: Vigor (POMS; p < 0.05) and Information Seeking and Affective Regulation (ICR; p < 0.01 and p < 0.05, respectively). CONCLUSIONS: While the brief intervention did not appear to influence HRQOL, or prostate-specific symptoms, it improved energy level and coping responses, particularly those relevant to managing information and emotions. These coping strategies may be especially important given the decision-making and treatment initiation tasks of early prostate cancer care. Source of financial support: California Cancer Research Program Grant #97–12013.

PCN22

THE EUROPEAN ORGANIZATION FOR RESEARCH AND TREATMENT OF CANCER QUALITY OF LIFE CORE QUESTIONNAIRE (EORTC QLQ-C30): VALIDATION OF ENGLISH VERSION IN SINGAPORE

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OBJECTIVE: To assess the validity and reliability of EORTC QLQ-C30 in patients with cancer in Singapore. METHODS: A total of 62 patients at Cancer Center of National University Hospital were asked to complete independently QLQ-C30 and a generic questionnaire (SF-36). The sociodemographic data were obtained simultaneously. RESULTS: The QLQ-C30 demonstrated good internal reliability for most scales with Cronbach’s alpha more than 0.7 except cognitive functioning, physical functioning, and nausea and vomiting scale. The majority of item-scale Pearson’s coefficients (corrected for overlap) were more than 0.4 and higher as opposed to that between the item and competing scales in the same instrument. All functioning scales in QLQ-C30 had strong correlations with the scales measuring the similar aspect of QoL in SF-36. The correlation coefficients among all scales were significant but modest (ranging from an absolute value of 0.23 to 0.65). CONCLUSION: In our study, QLQ-C30 could be considered reliable and valid using to evaluate health related quality of life (HRQoL) in cancer patients in Singapore.

PCN23

XEROSTOMIA SYMPTOMS: A NEWLY DEVELOPED PATIENT REPORTED OUTCOMES QUESTIONNAIRE

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OBJECTIVE: The majority of head and neck cancer (HNC) patients undergoing radiation experience xerostomia (dry mouth) which can range from mild to severe, even after completion of treatment. Its impact on quality of life (QoL) can be significant. The objective of this study was to evaluate the psychometric properties of a new questionnaire developed to assess the impact of xerostomia on QoL. METHODS: Data were obtained from radiation patients (RP) participating in the Evaluating Cytoprotection Health Outcomes (ECHO) Registry. ECHO, a prospective, longitudinal study of patients receiving amifostine prior to radiation and/or chemotherapy, collects clinical and outcomes information. All RP complete a questionnaire, including the Functional Assessment of Cancer Therapy-General (FACT-G) and a new questionnaire assessing xerostomia symptoms (XSQ) at baseline, 6-weeks (completion of radiation), and at 6 weeks, 3 months, and 6 months post treatment. RESULTS: A total of 104 with HNC, 43 with non-small cell lung cancer (NSCLC), and 38 with other cancer completed the questionnaire.
The majority were male, Caucasian, and insured. Average age was 59 years old. Based on variable clustering, the XSQ produced three scales—Xerostomia Interference (9-items), Pain (5-items), and Nausea and Vomiting Symptoms (3-items). Overall, internal consistency was acceptable (Cronbach’s alpha coefficients ranged from 0.81–0.96). Construct validity was demonstrated based on correlations between related items/scales. Known groups validity was upheld, as HNC patients reported statistically significantly lower scale scores (worse functioning) than NSCLC patients on all three domains (p < 0.05). As expected, no statistically significant differences were reported between the groups on the FACT-G scales. CONCLUSIONS: The XSQ was found to be reliable and valid in this population and should be a useful tool for clinicians to monitor their patients. Responsiveness will be evaluated in the future. The ECHO Registry is currently ongoing.

**PCN24**

**QUALITY OF LIFE OF NEWLY DIAGNOSED PROSTATE CANCER PATIENTS IN A PUBLIC VS. PRIVATE SETTING**

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OBJECTIVE: Demographic, clinical, social and economic factors influence the Health Related Quality of Life (HRQOL) and must be assessed in the management and treatment of diverse prostate cancer (PC) patients. The study objective is to analyze the variations in QoL of newly diagnosed PC patients across public and private facilities over the course of three months between public and private facilities. METHODS: A total of 316 newly diagnosed PC patients recruited from the urology clinics of a public university hospital and a veterans hospital completed SF-36 and UCLA-PCI prior to treatment, and at 3-month follow-up. RESULTS: General and Prostate-Specific QoL and demographics were compared across public and private facilities using t-test and chi-sq. Demographic characteristics varied significantly between the two groups. Privately-treated patients were predominantly Caucasian (83.66%), whereas publicly-treated patients were predominantly African American (66.23%, p < 0.0001). Privately-treated patients had significantly higher income and education levels, and were significantly more likely employed and married (61.35% vs. 20.00%; 54.59% vs. 14.29%). Baseline mean scores of general QoL demonstrated that publicly-treated patients were substantially less healthy by physical, psychological and social measures (mean physical function score of 47.53 compared to 70.46 for privately-treated patients (p < 0.005)). This was true for the PC-specific HRQoL also, though the differences were smaller. After three months, the mean scores for both groups declined from baseline levels though the groups’ relative divergence narrowed. Publicly-treated patients remained substantially less healthy as indicated by general HRQOL scores, but were less likely to report a worsening of disease or symptoms. CONCLUSIONS: Publicly-treated patients had significantly higher utilities for most levels of risk associated with impotence and incontinence as compared to those treated with 3DCRT. This is possibly related to either actual or perceived better sexual and urinary QOL for PB as compared to 3DCRT.

**CASE-MATCHED CONTROLLED STUDY SHOWS MEN PREFER PROSTATE BRACHYTHERAPY TO CONFORMAL RADIATION THERAPY**

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OBJECTIVES: Although there is no documented survival difference between 3-dimensional conformal radiation therapy (3DCRT) and prostate-brachytherapy (PB), some studies suggest a quality of life (QOL) advantage with PB. This study assessed patient preferences for risk of impotence and incontinence after PB and 3DCRT. METHODS: Preferences for PB were compared to age, Gleason-grade and pretreatment-PSA matched controls treated with 3DCRT, using a modified Time Trade-Off interview. Results for PB (permanent I-125 implants) were 0.78 to 4.22 (median 2.24) years post treatment (PT) with 145 Gy and men with 3DCRT were 0.75 to 6.07 (median 2.33) years PT with 74 Gy (37 fractions) to the prostate. RESULTS: Preferences were elicited from 51 men, (17 PB cases vs. 34 3DCRT matched controls). Mean age for the cases and controls were 62.2 years and 63.6 years, respectively. Mean pretreatment-PSA and Gleason scores were 7.1 ng/ml and 5.9 for cases and 6.6 ng/ml and 6.0 for controls, respectively. There were no significant differences among cases and controls regarding race, education or income. Differences in utilities were assessed using the Wilcoxon Test (one-sided). Utilities for a 40% risk of impotence were 0.96 (SD=0.08) for cases and 0.91 (SD=0.16) for controls, which were not significant (p = 0.09). However, utilities for an 80% risk of impotence were 0.93 (SD=0.12) for cases and 0.85 (SD=0.18) for controls (p = 0.03). Utilities for a 30% risk of incontinence were 0.96 (SD=0.12) for cases and 0.85 (SD=0.22) for controls (p = 0.008). Utilities for a 10% risk of incontinence were 0.98 (SD=0.06) for cases and 0.91 (SD=0.21) for controls (p = 0.05). CONCLUSIONS: Patients treated with PB have significantly higher utilities for most levels of risk associated with impotence and incontinence than those treated with 3DCRT. This is possibly related to either actual or perceived better sexual and urinary QOL for PB as compared to 3DCRT.

**ARE HEALTH STATES “TIMELESS”? A TEST OF THE UTILITY INDEPENDENCE ASSUMPTION USING A REPEATED MEASURES DESIGN**

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OBJECTIVES: To test whether individuals’ responses to standard gamble (SG) and visual analogue scale (VAS) questions do not depend on the time horizon of the health scenario presented. METHODS: Face-to-face interviews were conducted in a convenience sample aged 24 to 59 years at a Southern University in the US (n = 14). Preferences were estimated using SG and VAS. Individuals rated their preferences for three health states of varying severity of post chemotherapy nausea and vomiting (PONV) assuming different time horizons. Repeated measures analysis of variance (ANOVA) were conducted (SX6X2) for each health state to determine the affect of TIME (levels: 3 days, 3 months, 1 year, 5 years, 20 years and rest of life) and METHOD (levels: SG and VAS) on preference. RESULTS: Analysis showed that the time horizon used did affect an individual’s preference rating for SG and VAS. For all three models tested (OP, ST, NV), main effects TIME (F(5,65) = 10.71, F(5,65) = 13.85, F(5,65) = 17.40) and METHOD (F(1,13) = 34.56, F(1,13) = 58.01, F(1,13)