false-positive screening in breast cancer and lung cancer. However, several new lung-specific items were needed to obtain high content coverage and, consequently, make the COS-LC relevant to lung cancer screening. The questionnaire is currently in use in the Danish randomised study and will be validated using Item Response Theory (the Rasch model).

PCN75
WHAT CHOICES DO MEN FEEL THEY HAVE IN SELECTION OF PROSTATE CANCER TREATMENT?
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OBJECTIVES: The purpose is to prospectively describe factors that may influence the choice between surgery, radiation, and watchful waiting among men newly diagnosed with local stage prostate cancer. METHODS: Beginning in December 2005, prostate cancer patients were approached shortly after diagnosis at urology clinics in Texas, California and South Carolina. Patients took home a self-administered survey to complete as they made their treatment decision. Preliminary data are available for 148 men with recruitment continuing through 2007. Logistic regression was used to identify factors associated with choice of treatment. RESULTS: Overall 65% of men returned the survey before starting treatment. A total of 82% indicated they were only considering (had considered) a single option; 64% were only considering surgery, 9% were only considering radiation, 9% were only considering non-curative therapies, and 18% were considering multiple options or were unsure of their decision. Being married (OR 4.7; 95% CI: 1.1, 19.4), being under age 70 (OR 2.7; 95% CI: 1.0, 7.0), and having an annual household income higher than $60,000 (OR 2.9; 95% CI: 1.0, 8.1) were strongly associated with considering surgery only. CONCLUSION: Understanding why most men feel their only option is surgery is a priority to ensure that physician biases, patient misperceptions, or fear do not lead patients to select procedures that do not agree with their personal preferences. Many patients appear to make rapid treatment decisions. Interventions to aid treatment decision-making must target men soon after they receive their diagnosis.

PCN76
COMPARISON OF PHYSICIAN AND PATIENT PREFERENCES FOR COLORECTAL CANCER SCREENING USING A DISCRETE CHOICE EXPERIMENT
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OBJECTIVES: To measure and compare preferences for attributes of colorectal cancer (CRC) screening tests using a stated preference survey of the general population and physicians in Canada and the United States (US). METHODS: A stated preference survey was administered online with 11 choice tasks between two hypothetical CRC screening tests. Each test was described by nine attributes: process, pain, preparation, frequency, follow-up, complication risk, sensitivity, specificity, and out-of-pocket cost. Each scenario included a follow-up opt-out question to choose no screening. A total of 1087 US and 501 Canadian respondents participated and 100 physicians responded in both countries. Physicians were asked to indicate their patients’ preferences. Responses were modeled using bivariate regression with main effects and interactions with the opt-out term. Willingness-to-pay was calculated for common CRC screening tests. RESULTS: Physicians expected patients to choose the option of ‘no screening’ more frequently than patients themselves (55% vs 29% respectively, p < 0.001). For all groups the most important attribute was sensitivity, but physicians’ perception of patients’ preferences were significantly different from actual patient preferences. Other key attributes were those related to test performance or the testing process. Fecal DNA, colonoscopy, and virtual colonoscopy were the most preferred tests by all groups, but respondents were willing-to-pay more than physicians predicted. CONCLUSION: Physicians’ perception of patients’ preferences are significantly different from those of the general population, although both preferred tests with high sensitivity. The significant difference in the frequency of choosing no screening between physicians and their patients may have serious implications for CRC screening uptake since physicians generally exert a strong influence on decisions about healthcare treatment, and especially screening programs. Among general population and physicians, Canadian and US respondents’ preferences were similar.

EYE—Clinical Outcomes Studies

PEY1
USE OF BAYESIAN NETWORKS TO SPECIFY NOCTURNAL IOP CONTROL BY PROSTAGLANDIN ANALOGUES ACCORDING TO SEVERAL THRESHOLDS FROM DAY-TIME MEASUREMENTS IN GLAUCOMA PATIENTS
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OBJECTIVES: Intra-ocular pressure (IOP) fluctuation over 24 hours is an independent risk factor for glaucoma progression. Night-time IOP measurement is not a routine practice. The aim of this study was to predict the risk of a nocturnal IOP peak from day-time measurements. METHODS: IOP measurements from three clinical trials were pooled. The night-time IOP peak was defined as the maximum value observed between 00:00 h and 04:00 h. IOP measurements at 08:00 h, 12:00 h, 16:00 h, and 20:00 h were dichotomized using four thresholds: 15, 18, 21, and 25 mmHg. Patient IOPs were assessed during pre-treatment washout periods and after treatment with a prostaglandin analogue (PGA: latanoprost or travoprost). A Bayesian network (BN), adjusted for trial effects, was constructed to study the association between day-time IOP, nocturnal IOP, and treatment effects at each of the four thresholds. RESULTS: In total, 382 daily IOP vectors were identified (pre-treatment: 208; PGA: 174). The BN association structures differed according to threshold value. A direct drug effect on the night peak associated with IOP fluctuation was identified (BN), adjusted for trial effects, was constructed to study the association between day-time IOP, nocturnal IOP, and treatment effects at each of the four thresholds. RESULTS: In total, 382 daily IOP vectors were identified (pre-treatment: 208; PGA: 174). The BN association structures differed according to threshold value. A direct drug effect on the night peak associated with IOP fluctuation was identified (BN), adjusted for trial effects, was constructed to study the association between day-time IOP, nocturnal IOP, and treatment effects at each of the four thresholds. RESULTS: In total, 382 daily IOP vectors were identified (pre-treatment: 208; PGA: 174).
structures vary by IOP threshold values. Day-time IOP control with PGAs is associated with night-time IOP control whatever the IOP threshold.

PEY2

INTRA OCULAR PRESSURE CONTROL OF XALACOM ® (FIXED LATANOPROST AND TIMOLOL COMBINATION) AND DUOTRAV ® (FIXED TRAVOPROST AND TIMOLOL COMBINATION) IN DAILY PRACTICE

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OBJECTIVES: To confirm, in everyday practice, results from randomized clinical trials indicating that DuoTrav (a fixed travoprost and timolol combination) controls intra-ocular pressure (IOP) better than Xalacom (a fixed latanoprost and timolol combination), even when measured >24 hours after last instillation.

METHODS: Patients with ocular hypertension or primary open angle glaucoma and treated by one of the above combinations were included in this cross-sectional study. Demographics, medical history and previous treatments were abstracted from medical records. IOP and treatment time were collected during an office visit. Analyses of variance, logistic regressions and propensity scores were used to adjust for confounding factors.

RESULTS: In total, 328 patients were included, 127 treated with DuoTrav and 201 with Xalacom. The mean age was 64.6 years and 51.3% were female. Most (275: 84.6%) had last instilled treatment the previous day. Treatment groups were comparable except that Xalacom-treated patients had longer disease and treatment durations. Overall mean IOPs were 24.9 mmHg at diagnosis and 21.1 mmHg upon starting the fixed combination treatment. There was no significant difference between the groups as they started their second line therapy, DuoTrav-treated patients experienced better IOP control (17.1 versus 19.1 mmHg: p < 0.001). A difference was also noted for patients who missed their last scheduled treatment (17.2 versus 20.1 mmHg: p < 0.006). Better IOP control with DuoTrav was further supported by patients whose last instillation was 9.00–12.00 hours before IOP measurement (16.5 versus 19.3 mmHg: p < 0.001). According to the practitioners, 83.1% of the DuoTrav-treated patients attained their IOP targets, as compared to 51.3% of Xalacom-treated patients (p < 0.001). All these differences persisted after adjustment for confounding factors. CONCLUSION: This everyday practice study paralleled the published corresponding prostaglandin results of Topouzis and DuBiner, i.e. compared to Xalacom, IOP control with DuoTrav is better and has a longer residual effect when measured >24 hours later.

EYE—Cost Studies

RANIBIZUMAB (LUCENTIS®) IS A COST-EFFECTIVE TREATMENT OF AGE-RELATED MACULA DEGENERATION (AMD) IN THE GERMAN HEALTH CARE SYSTEM

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OBJECTIVES: The rationale for this study was to provide data for the German health care system in order to investigate the assumption that ranibizumab is a cost-effective option for the treatment of neovascular AMD. METHODS: We modeled cost-effectiveness for ranibizumab-treatment of the patient’s “better” eye based on the development of visual acuity in our phase III studies (ANCHOR/MARINA) compared to a control group who received best supportive care (e.g. visual aids, regular check-ups). In the base-case, we compared 6 treatments per year for 2 years and used the same patient entry age (77 years) and distribution of visual acuity of the model population as in our phase III studies. Utility values came from a study by Brazier et al. Costs and benefits were discounted annually at 5%. Costs of drugs and treatment procedures were determined based on German pharmacy retail prices, the German code book for physicians’ fees (EBM 2000plus) and German DRGs. We conducted a sensitivity analysis in order to test the stability of our model assumptions. Variations of the base-case scenario included e.g. patient age: 50–85 years, visual acuity at start of therapy: bw.< 4.0 and 0.05–0.1 or duration of therapy: 1–3 years. RESULTS: The base-case scenario yielded the following costs per QALY: 16.882 € for predominantly classic lesions, 24.766 € for minimally classic chorioidal neovascularization (CNV) and 26.170 € for occult CNV. When weighing the costs per QALY according to the distribution of these lesion types (18%–25%–57%), the mean costs per QALY for the therapy of wet AMD ranged between 0.05–0.1 or duration of therapy: 1–3 years. CONCLUSION: Therapy of neovascular AMD with ranibizumab is cost-effective for all angiographic subtypes assuming a realistic variation of model parameters.

PEY4

COST-EFFECTIVENESS ANALYSIS OF FIXED COMBINATION THERAPIES GANFORT, DUOTRAV AND XALACOM IN EUROPEAN COUNTRIES

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OBJECTIVES: Ganfort is a fixed combination product containing bimatoprost 0.03% and timolol 0.5% indicated for lowering IOP of patients with glaucoma or ocular hypertension. Other fixed combination products such as Xalacom (latanoprost 0.005% and timolol 0.5%) and Duotrav (travoprost 0.004% and timolol 0.5%) are also available on the market. All products have the advantage of being more convenient for the patient due to once-daily administration. Since no head to head studies compare the three combination products, an indirect comparison is used based on available clinical data. The purpose was to investigate the cost-effectiveness of the three fixed combination therapies in eight European countries. METHODS: A systematic literature search was conducted in order to identify randomized clinical trials of Duotrav and Xalacom. Studies were selected which had reduction in IOP as primary endpoint and which were comparable with data from randomized controlled trials of Ganfort with respect to study design, diagnosis and patient population, so that an indirect comparison could be conducted. A decision analytic cost-effectiveness model was constructed. The cost evaluated was cost of medication and clinical visits to an ophthalmologist. All drug costs are market prices inclusive of VAT and visit costs are priced using official tariffs. Patients discontinuing treatment due to adverse events were assumed to change therapy and had an extra clinical visit. RESULTS: The cost-effectiveness analysis showed that the cost per percentage reduction in IOP was least costly for Ganfort. By using Ganfort therapy, savings per percentage reduction in IOP ranged from €0.06 to €0.22 compared to Duotrav and €0.02 to €0.36 compared to Xalacom. CONCLUSION: This analysis concludes that