ABSTRACTS

RESEARCH PODIUM PRESENTATIONS

PODIUM SESSION I: CANCER OUTCOMES RESEARCH STUDIES

CA1

BREAST CANCER PATIENTS RECEIVING GUIDELINE-CONCORDANT ADJUVANT THERAPY REGIMENS HAVE BETTER ALL-CAUSE AND DISEASE-SPECIFIC SURVIVAL: NEW FINDINGS FROM RURAL GEORGIA

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OBJECTIVES: To examine whether receipt of chemo-, radiation, and hormonal therapy regimens that are jointly guideline concordant improve survival outcomes among women diagnosed with breast cancer in a rural region of the United States. METHODS: All women identified by the state cancer registry residing in rural southwest Georgia diagnosed with early stage breast cancer during 2001-2003 were included. Medical chart abstraction and state registry data were used to determine treatment concordance with guidelines established by the 2000 NIH consensus development conference on breast cancer treatment. Patients were Concordant versus Non-Concordant according to whether their receipt (or non-receipt) of each adjuvant therapy type was according to guidelines. To examine the effects of concordance on all-cause and breast cancer-specific survival, Cox models were developed that used both propensity score (PS) and 2-stage residual inclusion (2IRI) instrumental variable techniques to adjust for patient selection effects. RESULTS: In all-cause analyses, Concordance versus Non-Concordance was associated with significantly better survival (hazard ratios [HRs] 0.41 [95% CI 0.24-0.72] to 0.54 [95% CI 0.33-0.87]). Similar findings emerged in breast cancer-specific survival analyses, with HRs significantly less than 1.0 in most cases. Diagnosis at older age or later disease stage strongly predicted poorer survival outcome; being not married was significant in all-cause but not breast cancer-specific models. Survival was not generally associated with surgical treatment delay, insurance status, socioeconomic status, rural/urban status, comorbidities, tumor grade, or hormonal status. HR for black women versus white was greater than 1.0 across models but never significant (p<0.05). CONCLUSIONS: Breast cancer patients in rural Georgia who received guideline-concordant adjuvant therapy had significantly better all-cause and breast cancer-specific survival, based on Cox model analyses that attempted to control for multiple clinical and demographic factors, as well as selection effects. These findings extend the evidence that guideline bundles of care improve outcomes.

CA2

EVALUATION OF SURVIVAL OUTCOMES IN SELECT FIRST-LINE TREATMENT REGIMENS FOR ADVANCED NONSQUAMOUS NON-_SMALL CELL LUNG CANCER PATIENTS

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OBJECTIVES: Evidence from clinical trials supports the use of platinum agents in combination with pemetrexed or paclitaxel plus bevacizumab as first-line treatments of nonsquamous non-small cell lung cancer (NSCLC). This retrospective study was performed to evaluate survival outcomes from these select first-line treatments in a real-world clinical setting. METHODS: Patients with advanced (Stage IIIb/IV) nonsquamous NSCLC who initiated treatment with pemetrexed/platinum (Pem/Plat [n=122]), carboplatin/paclitaxel-bevacizumab (C/Pac+Bev [n=440]), or carboplatin/paclitaxel (C/Pac [n=989]) from July 2006 to January 2010 were identified in the McKesson Specialty Health iKnowMed electronic health record database of US Oncology community practices. Patients were included for at least one year or last available data stream to assess progression or death. Overall survival (OS) and progression-free survival (PFS) were calculated from treatment initiation to earliest of the following: progression (as defined by medical record, line of therapy), death, or end of study. Association between treatment and OS/PFS was assessed by using Kaplan-Meier and Cox regression analyses adjusting for age, gender, stage at diagnosis, Eastern Cooperative Oncology Group performance status, and comorbidity index. RESULTS: Patients with Pem/Plat had a median OS of 476 days compared to 348 days for C/Pac+Bev patients (adjusted hazard ratio [adj HR] 0.81, p=0.156) and 280 days for C/Pac patients (adj HR 0.70, p=0.012). Pem/Plat patients had a median PFS of 187 days compared to 225 days for C/Pac+Bev patients (adj HR 0.86, p=0.224) and 170 days for C/Pac patients (adj HR 0.78, p=0.038).

CONCLUSIONS: HRs for OS and PFS, which controlled for possible confounding factors, were significantly improved for patients treated with Pem/Plat compared to C/Pac. For Pem/Plat compared to C/Pac+Bev, the HRs for both OS and PFS were not statistically significant at this sample size.

CA3

TREATMENT PATTERNS AFTER CAstration RESISTANT PROSTATE CANCER (cRPC) DIAGNOSIS: A EUROPEAN PHYSICIAN SURVEY

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OBJECTIVES: Treatment for cRPC has evolved rapidly with new drug approvals. However, few studies have evaluated recent treatment patterns. Our objective was to describe treatment sequences after cRPC diagnosis in EU-5 countries (UK, Germany, Spain, Italy, France). METHODS: This study used IMS Oncology Analyzer, a proprietary database of patient chart abstractions, collected through a self-administered physician panel survey. The data includes the history of the patient’s cancer from diagnosis and treatment choices. The most recent panels of data (July 2011 – June 2012) were used to identify patients with physician-defined cRPC and to describe treatments initiated after cRPC diagnosis. RESULTS: 4479 prostate cancer patients, 624 patients had cRPC defined by the physicians (32% UK, 21% Germany, 18% Spain, 15% Italy, 14% France). A total of 76.4% of patients were >65y. A total of 57.7% were diagnosed with cRPC within the past year; 90.1% had metastases, mostly bone (80.4%). After cRPC diagnosis, 50.5% of patients (n=280) had docetaxel-alone specified as first therapy, of which 34.6% had a second treatment specified [52.5% chemotherapy, 40.2% androgen deprivation therapy (ADT) only]. Median time on first docetaxel therapy was 181 days; median number of cycles was five. A total of 24.5% of cRPC patients (n=136) continued with only single-agent ADT as first therapy, of which 53.7% had a second treatment specified [56.2% chemotherapy, 39.7% ADT; 2.7% combined chemo-ADT]. A total of 16.0% of cRPC patients had multiple-agent ADT specified as first therapy after cRPC diagnosis, and 3.4% had combined chemo-ADT. Of the 502 cRPC patients with bone metastases, 34.1% received zoledronic acid and 16.5% radiotherapy after their diagnosis of cRPC. CONCLUSIONS: Docetaxel was the most common first treatment after cRPC diagnosis, followed by continued ADT. Few physicians specified combined chemotherapy with ADT. Low rates of initiation of zoledronic acid in patients with bone metastases warrants study on alternative timings and choices.

CA4

THE USE OF TRANSARTERIAL CHemoEMBOLIZATION FOR TREATING HEPATOCELULAR CARCINOMA IN THE SEER-MEDICARE POPULATION

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OBJECTIVES: Transarterial chemoembolization (TACE) is a first-line therapy to treat hepatocellular carcinoma (HCC). Repeated TACE treatments are common. TACE is often used as a bridge-therapy to surgery or to treat tumor recurrence, and TACE-Sorafenib combination therapy is a promising new therapeutic approach based on synergistic properties. We explore historical patterns of TACE use and evaluate the effectiveness of TACE as it is utilized in a transformative therapeutic landscape for HCC. METHODS: Medicare enrollees with an initial diagnosis of primary HCC between 2000-2007, followed through 2009. Data are from the SEER and linked Medicare databases, with claims generated from Parts A and B. We describe rates of TACE use before and after transplant, resection, and ablation in the follow-up period. Among non-transplant/non-resection patients, we describe rates of multiple TACE treatments and use Kaplan-Meier analysis to examine mean weeks between HCC diagnosis, first TACE, repeated TACE, and death. RESULTS: There were 11,047 HCC patients. Among 411 transplants, 29%/33% received TACE before/after transplant. Among 851 resections, 23%/11% received TACE before/resection. Among 1116 ablations, 17%/19% received TACE before/after ablation. Among 1228 non-transplant/non-resection patients who received TACE, 57%, 24%, 11%, and 8% received 1, 2, 3, and 4+ TACE treatments, respectively; on average, TACE was discontinued at 35, 53, 95, and 125 weeks, and mean weeks survived post-ablation was 64, 61, 59, and 50 weeks, respectively. CONCLUSIONS: With transplantation, TACE has been more often used as a bridge-therapy, with resection, more often to treat non-optimal tumor response. TACE is frequently used concomitantly with ablation. Intent to treat first-line TACE patients with

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