Adenoma and Serrated neoplasia pathways (DECAS) was recently developed and calibrated using the German screening colonoscopy registry database, which consist of 5.2 million consecutive consultations between 2003-2011. The data is from the German national cancer registry data. We aim to use DECAS to estimate the length of protective effects of colonoscopy screening and the amount of colonoscopy needed in the German context. Methods: We used DECAS to simulate a cohort of averaged-risk individuals from age of 20 to 99 for three screening scenarios: (1) no screening; (2) one colonoscopy at age of 55; (3) two colonoscopies at age of 55 and 65. In the base-case analysis, we assumed the adenoma pathway accounting for 85% of the CRC development and the serrated pathway for the other 15%, as well as a 100% uptake of screening and surveillance colonoscopies. Outcomes of interest were hazard ratios (HR) of CRC-specific mortality under each screening scenario comparing to no screening, and the number of colonoscopies required. Results: DECAS predicted HRs of CRC-specific mortality at approximately 0.2 for both screening scenarios after 25 years of follow up, and the trend of both mortality HRs was still decreasing. The average numbers of colonoscopies required were 1,300 and 2,174 per 1,000 for once and twice colonoscopy screening, respectively. We also varied alternative screening and surveillance participation rates for sensitivity analyses. Conclusions: The modeling results from DECAS confirmed the long-term protective effects of colonoscopy screening and provided an estimation of the number of colonoscopies required in the German context. We will further apply DECAS to perform economic evaluations on various CRC screening strategies and policies.

PCN192
HOSPITALIZATIONS AND OUTPATIENT VISITS (H&OV) IN MODERATE AND SEVERE ACUTE GRAFT VERSUS HOST DISEASE (aGvHD) PATIENTS IN FINLAND AND SWEDEN
Italia-Rennes M, Viyana E, Niklasson M, Keränen M, Thiunstrom D, Pfeiffer M, Rosén N, Sabatelli LI, Naka M, Tuukkanen M
1Turku University Hospital, Turku, Finland, 2IQVIA, Barcelona, Spain, 3University of Gothenburg, Gothenburg, Sweden, 4Helsinki University Hospital, Helsinki, Finland, 5Incyte Biosciences International Sàrl, Morges, VD, Switzerland
Objectives: aGvHD is a frequent, and often very serious, complication of allogeneic hematopoietic stem cell transplantation (allo-HSCT). The objective of this study was to describe prophylaxis, clinical presentation, and H&OV in patients developing moderate or severe (grade II-IV, Modified Glucksberg or MAGIC) aGvHD. Methods: A retrospective chart audit including adult patients diagnosed with grade II-IV aGvHD following the first allo-HSCT (received between Jan-2016 and Jun-2017), and that had not experienced disease progression before aGvHD, was conducted in Finland and Sweden. Clinical characteristics, aGvHD prophylaxis treatment, H&OV were collected from clinical records since allo-HSCT (index date) until date of data collection, death or loss to follow up. Results: 55 patients were included. Mean (Standard Deviation, SD) age at transplant was 48.3 (14.4) years; 54.5% were male. At transplant, 61.8% of patients were in complete remission and 49.1% presented intermediate disease risk index. Most donors were unrelated (76.4%). Two unrelated and one related donor were HLA mismatched. Peripheral blood accounted for 96.4% of stem cells sources. Myeloablative (81.8%) and fludarabine-based reduced intensity conditioning (76.4%) were the most frequent conditioning types. aGvHD prophylaxis consisted of calcineurin inhibitors (98.2%), methotrexate (96.4%), and in-vivo T-cell depletion (80.0%). 70.9% and 29.1% of enrolled patients developed grade II or III-IV aGvHD. Forty-nine patients (89.1%) were hospitalised, mean (SD) number of hospitalizations was 2.9 (2.7). Each patient spent in hospital a mean (SD) of 48.4 (47.7) days. Reasons for hospital admission were aGvHD (65.3%) and infections (44.9%). Seven patients (14.3%) were admitted to intensive care units. Patients required on average (SD) 11.7 (11.1) outpatients and 0.3 (0.6) emergency visits per year. Conclusions: The present study reports key characteristics, prophylaxis treatment, and H&OV of patients developing moderate and severe aGvHD in Finland and Sweden, showing that aGvHD is associated with considerable healthcare resource utilisation in these populations.

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RESULTS AFTER 10 YEARS OF COLORECTAL CANCER SCREENINGS IN SPAIN: HOSPITAL INCIDENCE AND IN-HOSPITAL MORTALITY (2011-2016)
Darba J, Ascanio M, Marsa A
1Universitat de Barcelona, Barcelona, B, Spain, 2BCN HEALTH ECONOMICS & OUTCOMES RESEARCH SL, Barcelona, Spain
Objectives: This study aimed to update colorectal cancer incidence and mortality trends in Spain and provide a detailed analysis of disease management and risk factors involved in in-hospital mortality. Methods: Anonymous primary and specialist care admission records from 2011-2016 were extracted from a Spanish claims database representative of all Spanish regions. The standardised average expenses of medical procedures determined by the Spanish Ministry of Health were utilised for the calculation of direct medical costs. Results: Primary care files from 37,318 patients (56.1%) were retrieved and specialist care files from 192,048 patients (43.9%). In-hospital mortality rate was 10.07% and remained stable during the study period, similarly to colorectal cancer incidence within the hospitalised population, which was 106 per 10,000 patients. Patients deceased during the hospitalisation presented an increased presence of metastatic tumours. Mean length of hospital stay decreased significantly over the study period, similarly to patients’ 30-day readmission rate, which registered a 20.6% from the 15.29% to 13.58% (p<0.001). In consequence, the direct medical cost measured per patient, of €10,992, decreased over time. The implementation of colorectal cancer screening programmes caused a significant decrease in the number of new diagnoses in patients aged 75 to 79 years; however, in-hospital mortality rate was not reduced. Metastatic tumours and other conditions associated with anaemia are associated with higher in-hospital mortality rates. Conclusions: The implementation of colorectal cancer screening programmes in Spain presumably provoked the decrease in the number of new diagnoses in patients aged 75 to 79 years; however, no decrease in in-hospital mortality rate was observed. Further studies should be promoted to achieve higher participation rates in an effort to reduce incidence and the number of patients presenting metastasis at first admission. The roles of anaemia and overweight in colorectal cancer mortality should be further investigated to determine their value in improving patients’ prognosis.

PCN194
PREVALENCE OF MAJOR ADVERSE CARDIOVASCULAR EVENTS (MACE) IN PATIENTS WITH PROSTATE CANCER (PC) RECEIVING ANDROGEN DEPRIVATION THERAPY (ADT) IN THE UNITED STATES
Brady B, Pruitt J, Winer L, van Veenhuysen D, Dufour R
1IBM Watson Health, Laurel, MD, USA, 2Myovant Sciences, Brisbane, CA, USA, 3Myovant Sciences, Carmel, IN, USA
Objectives: Androgen deprivation therapy (ADT) with gonadotropin-releasing hormone (GnRH) receptor agonists is used to induce castration and prostate cancer (PC) cell death. Studies have shown an association between GnRH agonists and increased cardiovascular disease (CVD) risk; ~30% of men with PC have known CVD; cardiovascular mortality is the leading cause of death. In 2010, the Federal Drug Administration required new safety information to the labels of GnRH agonists warning of increased risk of CVD events in men receiving these medications for PC. We assessed the occurrence of major adverse cardiovascular events (MACE) and associated healthcare resource utilization (HCRU) in men with PC receiving agonist ADT. Methods: Men receiving ADT with ≥2 claims for a diagnosis of PC were identified in the MarketScan Commercial and Medicare Supplemental Database (1/1/2009-12/31/2018). Index date was the first ADT claim; patients had to be continuously enrolled for 12 months before and ≥ 2 months post-index. The occurrence of MACE (myocardial infarction, cerebrovascular accident, unstable angina, thromboembolism, percutaneous coronary intervention, and/or coronary bypass graft) was assessed over the study period. Post-period all-cause HCRU was evaluated for patients with and without MACE. Results: The study included 41,986 men; mean age was 70.1 (SD:10.3) years, and median duration of follow-up was 22.8 months. A total of 10,402 patients (24.8%) had a MACE during the study period (7.8% pre-index and 20.6% post-index). Patients with a MACE had three times the number of post-index inpatient admissions per-patient-per-month compared to patients without MACE (0.06 (SD:0.10) vs. 0.02(0.06), p<0.001). Conclusions: CVD is a known and important risk for patients with PC treated with GnRH agonists; 20% of patients in this analysis had a MACE following ADT. These patients were more likely to be hospitalized than patients without a MACE. Evaluating CVD history and risk in advanced PC patients when selecting treatment could help to reduce MACE and HCRU.

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IS IT TIME TO PUT CONFIDENTIAL DISCOUNTS FOR HIGH COST ONCOLOGICS ON BACK BURNER? MANAGED ENTRY AGREEMENT (MEA) SHOWS THE WAY FOR FASTER PATIENT ACCESS
Zhou V, Nash C, Duttagupta S
1DRI Consulting, New York, NY, USA, 2Decision Resources Group, New York, NY, USA
Objectives: Biopharmaceutical manufacturers have traditionally opted for negotiations involving direct confidential discounts to payers in order to gain patient access. However, with higher prices and concomitant clinical uncertainty associated with innovative therapies, manufacturers may be able to expedite time to access by offering MEA upfront during pricing negotiations than contemplating as a fall back option. Methods: A non-systematic review of literature supplemented by DRI’s proprietary MEA Database was used to construct a list of MEAs involving high-cost oncology products implemented in recent years in Italy, Spain, and UK. To access was derived from published literature for each country. Results: We reviewed 17 cases (majority of which were first-in-class products) where high priced oncology products reached patients faster than the median time to access in their respective countries based MEAs. Nine products (3%) were launched in UK, six (35%) in Italy, and two (12%) in Spain. All MEAs in UK involved manufacturer-led evidence development element, potentially highlighting the payer uncertainty around the clinical data. MEAs can provide faster access by allowing the payer to have median time to access, across these countries. For more innovative technologies (such as, cell therapies), access was 125 days faster on an average. The greatest number of days saved was 209 days, indicating payer acceptance of MEAs as a critical value in improving patients’ prognosis.