when non-surgical treatment was selected, the omission of brachytherapy should be avoided.

Disclosures The authors declare that they have no competing interests.

361

REAL-WORLD HEALTHCARE COSTS BY LINE OF THERAPY AMONG NEWLY DIAGNOSED CERVICAL CANCER PATIENTS AND CERVICAL CANCER PATIENTS NEWLY INITIATING SYSTEMIC THERAPIES

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Introduction/Background There are little data describing the economic burden among newly diagnosed and advanced cervical cancer patients, by line of therapy (L). NCCN recommends the use of systemic treatment for advanced cervical cancer patients. Therefore, this study aimed to assess healthcare costs among newly diagnosed cervical cancer patients and those newly initiating systemic treatments.

Methodology This was a retrospective observational study conducted using the Optum Clinformatics DataMart database. The first cohort consisted of cervical cancer patients newly diagnosed between January 2015 – June 2018, and continuous enrollment for 12 months prior and 6 months post diagnosis. The start of 1L was the date of the first treatment. Treatments initiated within 90 days of a surgery or the end of radiotherapy, and systemic treatment started within 28 days of any previous treatment were part of the same treatment line.

The second cohort consisted of cervical cancer patients with ≥ 2 claims for systemic therapy (i.e., chemo- or immunotherapy) within a 4-week period between June 2014 – October 2018, and continuously enrolled for 6 months prior and 3 months post therapy initiation. All claims for the same systemic therapy without a >90-day gap, or initiation of a new systemic therapy within 28 days of a previous treatment were attributed to the same treatment line. Claims for adjuvant systemic therapy (i.e., within ± 90 -days of a cervical cancer-related surgery) were excluded.

The per patient per month (PPPM) components of healthcare costs attributable to 1L and 2L were summarized for both cohorts (figures 1 and 2). Analyses for the second cohort were stratified by the presence of comorbid non-cervical cancers prior to systemic therapy initiation.

Results The first cohort included 655 patients who received at least 1L of which 162 received 2L. The mean PPPM healthcare cost from diagnosis to end of follow-up was \$10,121. The mean PPPM healthcare costs (figure 1) attributable to 2L (\$15,183) exceeded that of 1L (\$10,929).

The second cohort included 1,229 patients who newly initiated 1L of which 357 received 2L. The mean PPPM healthcare cost from initiation of systemic therapy to end of follow-up was \$15,463. The PPPM healthcare costs (figure 2) was higher during 2L versus 1L (without prior cancers: \$22,973 vs \$13,044; with prior cancers: \$19,822 vs \$16,387). Outpatient costs accounted for >70% of total PPPM healthcare costs attributable to 1L and 2L for both cohorts.

Conclusion Moving from 1L to 2L was associated with an increase in healthcare costs which may be indicative of disease progression/recurrence.

Abstract 361 Figure 1 Mean per patient per month healthcare costs by line of therapy among newly diagnosed cervical cancer patients

Abstract 361 Figure 2 Mean per patient per month healthcare costs by line of therapy among cervical cancer patients newly initiating systemic therapy

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363

STUDY OF NEOADJUVANT CHEMOTHERAPY WITH A CARBOPLATIN AND TAXOL FOLLOWED BY CHEMORADIATION VERSUS CHEMORADIATION FOR LOCALLY ADVANCED CERVICAL CANCER

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Introduction/Background The incidence of locally advanced cancer cervix (LACC) in developing countries is still high due to the absence of regular screening programs and vaccination. Besides, the survival in LACC patients remains low. So we conducted this study to evaluate the use of neoadjuvant chemotherapy (NAC) induction before the definitive concomitant chemoradiation (CCR) for downstaging of the tumor.

Methodology A 68 patients with LACC (International Federation of Gynecology and Obstetrics FIGO stage IB2 to IVA) randomly assigned to group A (received three cycles of NAC with Carboplatin AUC5 + Taxol 175 mg/m2 followed by the