themes emerged: Impact on the person, adjustment, external support and tailored individualised information. Participants explored how these factors assisted or hindered their recovery and what affected recovery. Participants not on a surgical pathway, those with shorter hospital stay, or outpatient care only, had less understanding of the need for, or availability of, rehabilitation services. Those who had longer hospital stays, i.e. the UGI patients, had better contact with rehabilitation professionals, especially physiotherapists and dietitians. Participants without Allied Health Professional (AHP) support reported a "drop-off" in professional support following treatment. Those with AHP support did not. Participants with GYN cancers accessed fewer rehabilitation services, expressed more psychosocial impacts and concerns regarding returning to work. Their younger median age and genders may explain some of those differences. It was often unclear to participants with unmet needs where to get guidance and help. Service inequalities were also identified; those treated as private patients received less inpatient and outpatient rehabilitation. Many participants felt that there were less services and support readily available than for others with more common cancer types. Most participants wanted individualised guidance to self-manage consequences of cancer and treatment rather than return to hospital for treatment.
Conclusions: Participants in this study reported seeking a new normality. Those who had contact with AHPs during treatment were more likely to feel supported and less likely to report unmet needs. These results will inform a future intervention study exploring the provision of individualised guidance at the end of treatment.

6638 POSTER

Medical Utilization and Cost of Liver Cancer in Taiwan

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Background: Taiwan implemented a comprehensive and universal National Health Insurance (NHI) program to cover all inhabitants. This study aimed to assess the medical utilization and cost of liver cancer patients under NHI in Taiwan.
Methods: This retrospective cross-sectional study used a sampled NHI research database containing one million beneficiaries. Claims of liver cancer patients in 2009 were analyzed.
Results: Among 2335 liver cancer patients identified, 2178 (93.3%) patients used outpatient services and 1193 (51.1%) patients used inpatient services. Liver cancer accounted 1.8% of the total cost of NHI. The cost per visit was $59.3 for outpatient and $2070.3 for inpatient. The annual cost per patient was $4746.6, with $1951.0 for outpatient and $2795.6 for inpatient. Patients who were female, age at 60's, lower income, living in Southern Taiwan, had higher cost per patient ($p < 0.0001$). Fees for consultation, treatment and medical supply (57.3%) accounted for the highest portion of outpatient cost, followed by drug fees (30.0%), and diagnosis fees (11.2%). Ward fees (19.0%) accounted for the highest portion of inpatient cost, followed by drug fees (18.7%), X-ray fees (14.9%). Private hospitals were visited most frequently.
Conclusions: The cost of liver cancer care is substantial and varied by sex, age, income, and geographic distribution. It is critical to identify cost-effective treatment strategies.

6639 POSTER

Polymorphisms Associated With the Clinical Outcome of Biliary Tract Cancer (BTC) Patients Treated With the Epirubicin, Cisplatin and Capecitabine (ECX) Regimen

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Background: Biliary tract cancers (BTC) are rare but highly fatal malignancies, and most chemotherapeutic agents have disappointing efficacy against these tumours. Our previous phase II study showed that combined locoregional and systemic chemotherapeutic regimen was active and safe, with results similar to the gemcitabine-platinum regimen (Cantore et al., Cancer 2005; Valle et al., N Engl J Med. 2010), but predictive factors for maximizing therapeutic efficacy are warranted. Therefore, this study was aimed at evaluating the association of polymorphisms in key genes with outcome of BTC patients (pts) treated with intraarterial cisplatin and epirubicin, and oral capecitabine (ECX) regimen.
Materials and Methods: We evaluated 5 polymorphisms in 4 genes (ERCC1, XPD, XRCC1 and TS) in 75 unresectable BTC pts treated upfront with ECX. Univariate/multivariate analyses compared clinical (age, sex, performance status (PS), CA19.9, cycle numbers) and genetic parameters with clinical response, overall and progression-free survival (OS, PFS).
Results: Patients harbouring a higher number of repeats in the TS promoter enhancer region (e.g., TSER 3R3R or 2R3R) experienced a significantly lower rate of clinical benefit (54 vs. 80%, $P = 0.03$) and shorter OS ($P = 0.001$, with median OS of 6.7, 9.0 and 19.3 months in pts with TSER 3R3R, 2R3R and 2R2R genotypes, respectively). CA19.9 levels above 100 U/ml were also associated with lower rate of clinical response and shorter OS, while no correlations were observed for all the other parameters. TSER polymorphic variants and CA19.9 remained as independent predictors for death-risk at Cox multivariate analysis, with HR = 0.440, 95% CI, 0.237–0.818 for 2R2R vs. 2R3R/3R3R pts ($P = 0.009$).
Conclusions: TSER polymorphisms have been already associated with differential outcome in cancer pts treated with fluoropyrimidine-based regimens, but this is the first evidence about their predictive role in BTC pts treated with ECX regimen. Since BTC are such a dismal disease, any biomarker that can help to better stratify patients might have crucial clinical applications. The validation of the role of these polymorphisms in well-planned prospective trials will offer new tools for optimization of currently available treatments in selected patients.

Oral Presentations (Sun, 25 Sep, 09:00−10:20)
Genitourinary Malignancies − Prostate Cancer

7000 ORAL

Final Overall Survival (OS) Analysis of COU-AA-301, a Phase 3 Study of Abiraterone Acetate Plus Prednisone in Patients With Metastatic Castration-Resistant Prostate Cancer (mCRPC) Pretreated With Docetaxel

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Background: Abiraterone acetate (AA) is a selective androgen biosynthesis inhibitor that blocks the action of CYP17, thereby inhibiting adrenal and intratumoral androgen synthesis.
Materials and Methods: COU-AA-301 is a randomised, double-blind study of AA (1000 mg + prednisone [P] 5 mg po BID) vs placebo + P administered to men with mCRPC progressing post-docetaxel. 797 patients were randomised to AA and 398 to placebo. OS was the primary end point. At a preplanned interim analysis, AA improved OS (de Bono, ESMO 2010). The present report describes the final OS analysis at 775 events (prior to crossover from placebo to AA).
Results: At median follow-up of 20.2 mos, OS for the AA + P group was superior to the placebo + P group [median OS 15.8 vs 11.2 mos; HR = 0.74 (0.64–0.86), $p < 0.0001$]. The difference in median OS between the 2 groups improved to 4.6 mos from 3.9 mos (interim analysis). Mean duration of treatment was 10.1 cycles AA vs 6.7 placebo. Subgroup analyses for OS are presented in the table.

		Median OS (mos)			
Baseline variable	Subgroup	AA	Placebo	HR	95% CI
All subjects		15.8	11.2	0.74	0.64–0.86
Brief Pain Inventory-worst pain (BPI-SF)	<4	18.4	13.9	0.69	0.56–0.85
	⩾ 4	13.3	9.3	0.78	0.63–0.96
Prior regimens	1	17.1	11.7	0.71	0.59–0.85
	2	14.2	10.4	0.80	0.61–1.03
Type of progression	PSA only	18.3	13.6	0.63	0.47–0.84
	Radiographic	14.8	10.5	0.78	0.65–0.93
Age, y	<65	15	11.2	0.69	0.53–0.91
	⩾ 65	16.2	11.1	0.76	0.63–0.90
	⩾ 75	15.6	9.3	0.64	0.48–0.85
Visceral disease at entry	Yes	12.9	8.3	0.79	0.59–1.05
	No	17.1	12.3	0.69	0.58–0.82

AA was well tolerated. Mineralocorticoid-related adverse events were more common with AA vs placebo. Grade 3/4 hypokalaemia (4.4% vs 0.8%), and grade 3/4 hypertension (1.3% vs 0.3%) were infrequent. Liver function test