cancer registries. *CVD outcomes:* acute myocardial infarction, angina pectoris, pericarditis, valvular dysfunction, cardiomyopathy, dysrhthymia, congestive heart failure and stroke. *Exposure:* Completed radiation treatment (RT) *Statistical analysis:* Adjusted hazard ratios (HR) and 95% confidence intervals were estimated using Cox models with time dependent tamoxifen & radiotherapy use status. Covariates included age, year of diagnosis, race/ethnicity, stage, ER/PR status, laterality, comorbidities & health plan. **Results:** When comparing women who received RT with those who did not (full cohort, n=806), radiotherapy was not associated with greater risk of CVD after adjusting for multiple covariates including laterality (Table 2). However, within the subset exposed to RT (n=340), women treated for cancer of the left breast had a significant increase in CVD risk (HR=1.54, 1.07-2.23) compared with women treated with RT for the right breast. **Conclusions:** Preliminary results demonstrate that RT to the left breast may be associated with greater CVD risk. Our next study, "Long-Term Survivorship in Older Women with Early Stage Breast Cancer"(BOWII), will follow these women for an additional 5 years. This study will collect a wider set of risk factors for CVD to further evaluate these findings (2RO1CA093772-05A2 R. Silliman).
Keywords: Cancer, Cardiovascular disease, Radiotherapy
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C-A5-03:
Rapid Estimates of the Costs of Diagnosing Lung Cancers

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Background/Aims: The HMO Cancer Research Network received a request from the National Cancer Institute to provide an empirical estimate of the medical care costs of diagnosing lung cancers within a typical HMO setting. This estimate had to be completed within 24 hours. This paper summarizes the methods and data we used to generate our response to this request. We assumed that services delivered during the 90 days prior to the date of the lung cancer diagnosis would provide an acceptable order-of-magnitude estimate of the costs of a diagnosis work-up. We further assumed that additional imaging procedures performed after the date of diagnosis represented treatment costs because their primary purpose was to assist physicians in developing treatment plans. **Methods:** This analysis was conducted in four large group-model HMOs: Group Health Cooperative, Kaiser Permanente Colorado, Kaiser Permanente Northern California, and Kaiser Permanente Northwest. To be included in the estimates, patients with lung cancer had to be enrolled in one of the four participating health plans for at least 30 days between January 1, 2000 and December 31, 2008. Patients also had to have their lung cancers diagnosed at least 90 days after their effective date of enrollment. Furthermore, patients diagnosed at autopsy were excluded. The following elements of medical care utilization were included: hospitalizations, inpatient days, surgical procedures, doctor office visits, imaging procedures, laboratory tests, and medication dispensings. Outpatient procedures were weighted by Medicare's Resource-based Relative Value System (RBRVS). We used Medicare's RBRVS-to-dollars conversion coefficient for 2008 to compute total ambulatory care expenses. Inpatient expenses were computed by a DRG-weighted per diem cost (which preserved variations in lengths of stay). We also identified specific surgical, imaging, and laboratory procedures that were most consistent with a diagnostic work-up for a pulmonary disease in general and lung cancer in particular. **Results:** We were able to develop and run VDW programs to identify the study population in the four health plans; extract and summarize each utilization element; attach monetary weights to each service; and compute total costs of care for the diagnosis phase. **Conclusions:** Rapid costing is feasible for the CRN.
Keywords: Cancer, Costs, Diagnosis
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C-C1-03:
A GPS for Navigating Sensitive Research Topics: The Case of Adverse Events in Oncology

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Background: Adverse events and medical errors are challenging aspects of clinical care delivery, and also present challenges as topics for research. Nonetheless, understanding how and why such errors occur is critical to rendering improvements. Using examples from a multi-site study of problems in cancer care, we identify potential pitfalls and strategies to consider when researching sensitive or thorny topics in our delivery systems. **Methods:** In the context of the CRN Cancer Communication Research Center our team is studying adverse events and medical errors in cancer care (both in primary and specialty care settings), and how communication could be use to prevent problems and/or respond to patients when something goes wrong in their care. Throughout the course of developing the study, the three sites encountered challenging dilemmas pertaining to risk management, quality improvement, stakeholder "buy-in" to the study idea, and IRB review. **Results:** Case studies within the larger context of a study on communication in cancer care will be presented to illustrate our approaches to addressing the challenges in each area. We will review how, in some instances, the anticipated challenges did not manifest themselves, and what has been required on the part of the study team to ensure ongoing buy-in, even as findings from the actual research study illuminate deficits in care. **Conclusions:** Sensitive research topics, especially those which may reveal opportunities for improving medical care, or confronting a persistent problem in quality of care, require particular attention to partnerships with key leaders, frequent communication, and an openness to modifying the research to meet the needs of both the study team and the clinical setting.
Keywords: Communication, Cancer, Quality of care
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C-C1-04:
Use of Health Plan EMR Data to Identify Chemotherapy Regimens for Advanced Lung Cancer

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Background: Several studies have demonstrated that chemotherapy prolongs survival by upwards of 3 months in patients with advanced (stage IIIb-IV) non-small cell lung cancer (NSCLC), but often at considerable costs. Analyses of SEER-Medicare data suggests that only 25% of older patients receive chemotherapy, however, little is known about how these treatment rates compare to younger patients and to those receiving care in an HMO. **Aims:** Using the HMO Cancer Research Network's (CRN) Virtual Data Warehouse (VDW) at 4 CRN sites, we examine the characteristics of stage lIIb-IV NSCLC patients who receive chemotherapy, and we assess the first-line chemotherapy patterns overtime. **Methods:** Patients aged =21 years with stage IIIb and IV NSCLC diagnosed between 2000-2007 at 4 CRN sites were included in the analysis. Patients were followed from diagnosis date through the end of 2008 (or death or disenrollment). Patient characteristics, clinical information, chemotherapy treatment data, and mortality were obtained from the CRN Virtual Data Warehouse. Current Procedural Terminology codes and National Drug Codes from the VDW were used to identify chemotherapy regimens. Descriptive statistics were performed to describe the study samples, both overall, overtime, and by subgroups (age category, stage, etc). Differences in the proportion of patients receiving various chemotherapy regimens, (by health plan, age category, stage, etc) were tested using