(REC-L; N = 43) and patients with metastatic recurrence with or without locoregional recurrence (REC-M(L); N = 24). Data on treatments were collected during a one-year follow-up. Cost evaluation was made from the point of view of the French National Health Insurance.

Results: Primary tumor of the P-RES group was treated by surgery only in 18% of patients; 80% had radiotherapy, either alone (60%) or in combination with chemotherapy (20%). In the P-NR group, nearly all patients had radiotherapy, either alone (42%) or in combination with chemotherapy (48%). The mean global cost per patient was higher in group P-RES (FF 117,000 versus FF 73,000) because of the impact of surgery. Costs of radiotherapy were FF 32,000 in group P-RES versus FF 42,000 in group P-NR. Costs of chemotherapy treatments were about FF 35,000 per patient treated with chemotherapy in either group.

A majority (60%) of recurrent patients received only one type of treatment (mostly chemotherapy). Different regimens of mono- and combination chemotherapy were analysed. Association of treatments is more frequent (49%) when recurrence is only locoregional: the most frequent association is radiotherapy + chemotherapy (30%), with (9%) or without (21%) surgery. Chemotherapy alone prevails in presence of metastases. The mean global cost per patient was higher for patients with locoregional recurrence (L = FF 91,000; L+M = FF 104,000), because of the impact of surgery. As for patients with metastatic recurrence, mean global hospital costs was FF 78,000, chemotherapy accounting for about 74% of this amount. The mean cost of all chemotherapy treatments was FF 58,000, whatever the type of recurrence.

Conclusion: Costs assessment for patients with HNSCC becomes critical as increasing numbers of patients receive chemotherapy. Proper distribution of Health Care budget will allow to achieve utilization of new therapeutic scenarios.

856 POSTER

Gemzar in the treatment of pancreatic cancer in the UK: An economic evaluation

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Purpose: This study reports on an economic evaluation of Gemzar relative to 5-FU, for the treatment of pancreatic cancer.

Methods: The perspective is that of the UK-NHS. Data were derived from a clinical trial (Burris 1998). Total treatment costs estimates are based on chemotherapy, infusions, hospitalisations, visits to health care professionals and concomitant medications. Resource utilisation data, derived from the trial, were combined with unit cost data from various UK sources. Extensive sensitivity analysis was performed to test the robustness of the results.

Results: Total treatment cost per patient on Gemzar was estimated at £3,569 and on 5-FU at £1,262 – largely attributed to drug costs. Gemzar was associated with an incremental gain of 0.188 life years, 0.116 progression-free-life-years and 19% of patients could be classifed as clinical benefit responders. As such, relative to 5-FU, the incremental cost-per-clinical-benefit-responder with Gemzar is £12,172, the incremental cost-per-life-year-gained is £12,206 and the incremental cost-per-progression-free-life-year gained is £19,888. Sensitivity analyses showed that the results did not vary significantly with changes of the parameters. When 5-FU is administered by continuous infusion, the incremental cost-effectiveness of Gemzar is improved.

Conclusions: This economic evaluation demonstrates that Gemzar is a cost-effective treatment compared to 5-FU in the treatment of pancreatic cancer in the context of the UK NHS.

857 POSTER

Economic evaluation of Gemzar/cisplatin relative to other cisplatin based treatments for non small cell lung (NSCLC) cancer in the UK

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Purpose: This study reports on an economic evaluation of Gemzar/cisplatin (GC) relative to: mitomycin/ifosfamide/cisplatin (MIC), etoposide/cisplatin (PE) and mitomycin/vinblastine/cisplatin (MVP).

Methods: The study perspective is that of the UK-NHS. Data were derived from comparative clinical trials (Crino 1999, Cardenal 1997, Costa 2000). Costing is based on: chemotherapy, infusion, hospitalisations, visits to health care professionals and concomitant medications. Costs were assesses over a one year period and outcomes were based on data from the clinical trials

Results: In the first setting the cost-per-patient on GC was £5,101 and on MIC £4,481. Overall tumour response rates were 39.6% and 27.6% respectively. Thus, the incremental cost-per-tumour-response of GC was £5,169. In the second setting, the cost on GC was £4,142 compared to £3,762 on PE. Overall tumour response was 40.6% and 21.9% and progression-free life years 0.575 and 0.358. Thus, the incremental cost-per-tumour-response of GC was £2,032 and the incremental cost-per-progression-free-life-year £1,751. In the final setting, the cost of GC was £5,084 and of MVP £4,004. Overall tumour response was 54.0% and 36.7% and one year survival 36% and 17%. The incremental cost-per-tumour-response of GC was £6,240 and the incremental cost-per-survivor-at-one-year was £5,681. In extreme changes to underlying variables the above ratios vary from dominance to a maximum of £14,000.

Conclusions: These results demonstrate that G/C represents a relatively cost-effective treatment for NSCLC with ratios comparable or below those of therapies currently in use within the NHS.

858 POSTER

An economic evaluation of different chemotherapy regimens used in the treatment of advanced colorectal cancer (ACRC) in a Cooperative Group

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Background: Significant changes appeared in the field of chemotherapy (CT)for ACRC in recent years. New drugs and combination schedules has been introduced. Effects on costs are yet not completely accounted. Economic evaluation is needed for new approaches and new drugs.

Purpose: Economic evaluation model applied to the costs of treating ACRC in Spain in Oncology Units Hospital-based. Treatment schedules of 6 consecutive Phase II multicenter trials has been analysed.

Method: Total monthly amount has been calculated in pesetas (pts) and euros. Standarized dose for 1.7 m2 body surface has been used. The economic model includes: drug cost (per mg), pumps and infusional devices (including surgical implant procedure), blood tests, X-rays, costs of preparation specific drugs, staff costs (nurse-time for administration and doctor-time for visit of the patient). The public center medium salary has been used. The costs has not been taken in account are: premedication drugs, treatment of complication/secondary effects, refunds and travel expenditures.

Results: Monthly drug-cost for treating ACRC can vary form 6.654 pts (39.9 euros) to 268.524 pts (1613.8 euros)using different schedules that has been published. Our model has been applied to 6 different CT-regimens testes in consecutive Phase II trials in the setting of the Cooperative Group: 5-Fluorouracil (5FU) plus low-dose Folinic Acid (FA) (Mayo schedule), 5FU continuous infusion (c.i.)48 h weekly (TTD schedule), 5FU c.i. weekly plus Oxaliplatin (OHL-P)biweekly, 5FU c.i. plus CPT-11 both weekly, Tegafur-Uracil (UFT) plus F.A. by mouth (p.o.) and UFT p.o. as single agent. The monthly costs for every schedule using this model are: 45.925 pts/276 euros for 5FU bolus plus FA; 103.346 pts/621.1 euros for 5FU c.i.; 315.715 pts/1897.4 euros for 5FU c.i. plus OHL-P; 265.822 pts/1597.6 euros for 5FU plus CPT-11; 77.192 pts/468.2 euros for UFT plus FA and 41.008 pts/246.4 euros for UFT.

Conclusions: The new drugs and schedules cause an incremental costs for treating ACRC. The drug-cost can vary 40x. The present model including other charges limit the variability to 7x. These analyses open possibilities to identify other relevant costs and to reduce this costs modifying administration procedures and follow-up. The results of cost-benefit analysis based on the modeled-results (time to progression and survival) of the analysed Phase II trials will be presented.

859 POSTER

Pharmacoeconomic analysis of advanced non-small cell lung cancer treatment with docetaxel-cisplatin, paclitaxel-cisplatin and paclitaxel-carboplatin

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Purpose: To compare the efficiency (the evaluation of efficacy in relation