ience measures and utility values for individual treatment attributes. Differential toxicity attributes, that were patient relevant and clinically significant, were identified from head-to-head trial data. Attributes identified were: alopecia, weight loss, mucositis, diarrhoea, and febrile neutropenia/neutropenic sepsis. Fourteen oncologists and 16 oncology nurses served as patient proxies given the sensitive nature and ethical difficulties associated with the patient population. Respondents considered an orthogonally designed series of pair-wise choice scenarios representing incidence levels for individual toxicity attributes (treatment features) with trade-offs in life-expectancy. A logistic regression was utilised to analyse the stated scenario pair preferences against the individual attribute levels. Potential confounders were analysed. RESULTS: Survey results indicate a strong preference for GC treatment and a clear willingness-to-trade-time for tolerability benefits. Analysis of strength of preference for individual attributes shows strong support for treatment features that impact directly on QoL. CONCLUSIONS: UK respondents displayed a clear preference for GC treatment with superior toxicity offering a highly valued health related QoL gain. These results provide encouragement for further exploration, possibly by extension to the European setting. Discrete choice conjoint analysis is a promising instrument in the outcomes assessment of cancer therapies.

CANCER—Clinical Outcomes

IS THERE DIFFERENCE BETWEEN GEMCITABINE BASED NSCLC TREATMENT AND OTHER PLATINUM BASED COMBINATIONS FOR RESPONSE RATES AND TOXICITY?
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OBJECTIVE: This analysis attempts to highlight the differences in response rates and toxicity between Gencitabine combined with a platinum-based therapy and other combinations of platinum-based chemotherapy, in the treatment of non-small-cell lung cancer (NSCLC). METHODS: This pooled analysis used summary statistics from clinical trials published up to December 2001. The analysis pooled odds ratios (OR) and associated confidence intervals (CI) using a fixed-effects model. The efficacy outcomes considered are responses (both partial and complete) and progressive disease. Grade 3 and 4 toxicities are considered using the WHO criteria for the following adverse events: alopecia, nausea and vomiting, anaemia, neutropenia, thrombocytopenia and neuropathy. RESULTS: Patients receiving Gencitabine combined with a platinum therapy are more likely to experience a response to treatment than patients receiving other platinum based combinations. The OR for complete and partial responses is 2.68, (CI 1.53–4.67) and is 0.44 for progressive disease (CI 0.32–0.59). Gencitabine patients experienced fewer cases of alopecia (OR 0.15, CI 0.10–0.22) and neutropenia (OR 0.6, CI 0.47–0.77). In contrast, Gencitabine patients experienced a greater number of grade 3 or 4 anaemia (OR 1.92, CI 1.41–2.61) and thrombocytopenia (OR 6.76 CI 4.95–9.23) incidences. For neuropathy and nausea and vomiting there was no evidence for any of the chemotherapies having fewer patients experiencing toxicities. CONCLUSIONS: The implications of this analysis at the patient level is that if response is of primary importance, then on a purely clinical basis Gencitabine should be the treatment of choice. Gemzar based chemotherapy had a higher number of responses and fewer adverse events for alopecia and neutropenia. To validate these results, a meta-analysis should be conducted with stratification for key variables using patient level data.

CANCER CHEMOTHERAPY AT HOME: FEASIBILITY, PATIENT OUTCOMES, AND HEALTHCARE SYSTEM IMPLICATIONS
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OBJECTIVES: At the Quebec Health Technology Assessment Agency (AETMIS) in Canada we assessed whether home chemotherapy for cancer was effective, safe, and satisfactory to patients, and examined the cost, organizational, and ethical implications, in order to make policy recommendations. METHODS: We carried out a systematic review of the scientific literature using the PubMed (MEDLINE 1980–present) and CancerLit (1975–present) bibliographic databases. We supplemented this review with 16 semi-structured interviews with service providers, including oncology nurses, physicians, and home care coordinators, in 2 provinces with different organizational structures for cancer care (Quebec and Ontario). RESULTS: Clinical effectiveness of home cancer chemotherapy appears similar to that in non-home settings. Home treatment can be delivered safely if patients are carefully selected and trained. Patient eligibility criteria relate to learning capability, suitability of the home environment, and geographic accessibility. Improvements in patient quality of life at home have not been well documented in the literature. Patient preference and satisfaction with home therapy is supported, although mostly among self-selected groups. Cost studies show that home chemotherapy is less expensive than inpatient treatment from a hospital perspective. When home treatment is used as a substitute for outpatient therapy, the result tends to be a cost shifting from hospitals to home care organizations. Effects on costs to patients/families require more study. Interviews with service providers showed variable delivery, with greater patient load capacity and uniformity of services where hospital oncology departments or regionalized centres
of expertise have organized, collaborative links with community home care services and sufficient resources. CONCLUSIONS: Home chemotherapy requires a well-integrated multidisciplinary team of health professionals in partnership with selected patients and their informal caregivers. Our study shows the need for regionalized approaches within centralized standard setting and funding, increased resources and support for program evaluation, and a comprehensive cancer care model.

DIABETES—Economic Outcomes

PDB1

COST-EFFECTIVENESS OF SWITCHING PATIENTS TO COMBINED GLIBENCLAMIDE AND METFORMIN (GLUCOVANCE) WHEN POORLY CONTROLLED WITH METFORMIN MONOTHERAPY: THE FRENCH PERSPECTIVE

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OBJECTIVES: Poor glycaemic control is associated with increased risk of micro- and macro-vascular disease in type 2 diabetes (T2D) patients. Switching patients from metformin to Glucovance (combined glibenclamide/metformin) leads to improved glycaemic control in previously poorly controlled patients. No long-term studies have been performed that compare complication rates, mortality, and long-term costs in patients switched from metformin to Glucovance. A method was sought to link the effects on glycaemic control of switching from metformin to Glucovance to long-term complication rates and associated costs. METHODS: A validated model was used to quantify the improvements in life expectancy (LE), the changes in total lifetime costs (TC) associated with the improved glycaemic control seen with switching patients from metformin to Glucovance. Standard Markov modelling was used to describe the long-term incidence and progression of diabetes-related complications (angina, MI, stroke, heart failure, peripheral vascular disease, neuropathy, foot ulcer, amputation, renal disease, and eye disease). Probabilities of complications and HbA1c-dependent adjustments were derived from published studies. Switching from metformin to Glucovance lead to a 1% point improvement in HbA1c. Direct costs of diabetes complications and treatment with either metformin or Glucovance were projected over patients’ lifetimes (discounted 5% p.a.). Costs of complications were retrieved from published sources. A French third party payer perspective was taken. A typical type 2 diabetes cohort (baseline age of 59) was simulated over a 30 years period. Extensive sensitivity analysis was performed. RESULTS: Improved glycaemic control after switching from metformin to Glucovance lead to decreased incidence and progression of diabetes-related complications, with an increase in LE of 0.80 years, and reduction in TC/patient of €2,050. CONCLUSIONS: Switching from metformin to Glucovance is dominant to maintaining patients on MET monotherapy with poor control. Further long-term clinical studies with economic data collection are required to confirm these results.

PDB2

COST-EFFECTIVENESS ANALYSIS OF GLYCEMIC CONTROL WITH PIOGLITAZONE HYDROCHLORIDE FOR JAPANESE PATIENTS WITH TYPE II DIABETES

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OBJECTIVES: To estimate the cost-effectiveness of glycemic control with pioglitazone hydrochloride compared to conventional treatment for Japanese patients with Type II diabetes. METHODS: This study used the Japanese Diabetes Risk Simulation Software to estimate the lifetime cost per life-year or quality-adjusted life year (QALY). The hypothetical cohort was comprised of 1000 individuals living in Japan, aged 50 years, who were newly diagnosed as having Type II diabetes without retinopathy, nephropathy complications or history of coronary heart disease (CHD). Clinical effectiveness data were taken from the results of clinical trials conducted in Japan. Cost data were based on the fee schedule used for hospital outpatients in 2000. Costs (in 2000, Japanese yen), life expectancy and QALYs were discounted at 3% per annum. RESULTS: Glycemic control with pioglitazone hydrochloride reduced the cumulative incidence of blindness, dialysis and CHD by 22.2%, 12.2% and 7.9%, respectively. As a result, it produced a net saving of 390,000 yen per patient over the lifetime despite the additional annual cost of 70,000 yen for pharmacotherapy. Increased life expectancy was 0.61 years, and 0.68 QALYs was gained. CONCLUSIONS: Glycemic control with pioglitazone hydrochloride reduces costs and improves health outcomes relative to conventional treatment in patients with Type II diabetes in Japanese clinical settings.

PDB3

INTENSIVE LIFESTYLE CHANGES OR METFORMIN IN OVERWEIGHT, GLUCOSE INTOLERANT PATIENTS: MODELING THE LONG-TERM HEALTH ECONOMICS IMPLICATIONS OF THE DIABETES PREVENTION PROGRAM IN THE FRENCH, GERMAN, AND UK SETTINGS

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OBJECTIVES: In the Diabetes Prevention Program (DPP), overweight patients with impaired glucose tolerance randomized to either intensive lifestyle changes (ILC) or metformin (MET) reduced their risk of develop-