during treatment of acute lymphoblastic leukemia (ALL) in childhood. **METHODS:** Patients were age five years or older at time of study and enrolled in Dana Farber Cancer Institute 95-001 clinical trial. Parents-of-patients and clinicians, blinded to each other, completed self-administered HUI questionnaires at four assessment points during treatment: Induction of remission, CNS prophylaxis, intensification, and maintenance. Agreement between parents and clinicians, for HUI3 single-attribute and overall health-related quality of life (HRQL) utility scores, was assessed using a single-measure two-way mixed model intra-class correlation coefficient (ICC) and paired t-test. Mean differences in single-attribute and HRQL scores >0.05 and >0.03, respectively, are clinically important. Statistical significance was set at p < 0.05. ICC results were interpreted as follows: >0.50 strong agreement; 0.35–0.50 moderate agreement; 0.20–0.34 weak agreement; 0.00–0.19 negligible agreement. **RESULTS:** There were 375 patients who were surveyed (55.2% males). The number of pairs of parent and clinician assessments varied by assessment point (minimum = 104, maximum = 180). There was moderate or better agreement between raters (p < 0.05) at all assessment points for ambulation (ICC = 0.51–0.84) and pain (ICC = 0.39–0.84). Weak or better agreement (p < 0.05) was observed at all assessment points for vision (ICC = 0.23–0.79), and emotion (ICC = 0.22–0.69). Inter-rater agreement for HRQL ranged from weak to moderate (ICC = 0.31–0.50, p < 0.05). There was no significant agreement (p > 0.05) for dexterity at any assessment point (ICC = 0.05–0.16) and for cognition at Induction (ICC < 0.01). The mean difference (clinician minus parent) was clinically important for HRQL (difference = 0.07, p = 0.01) at Maintenance. **CONCLUSIONS:** Inter-rater agreement varies, from none to strong, by both type of utility score and assessment point. A clinically important mean difference in HRQL scores was observed. Parent and clinician reports should not be considered interchangeable. The results are consistent with studies of ALL patients assessed after completion of therapy.

**PCN27**

**HEALTH STATUS MEASURES AS PREDICTORS OF MORTALITY AMONG ADULTS WITH BRAIN TUMORS**

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**OBJECTIVES:** The five-year mortality rate for a population of adult brain tumor patients is typically high (≥50%). Tumor grade is a well-known predictor for mortality: low-grade (LG) tumors are associated with lower mortality rates than are high-grade (HG) tumors. **METHODS:** Prospective study of consecutive patients newly diagnosed with primary brain tumors attending a single regional centre. A cross-sectional survey collected baseline health status assessments for each patient after diagnosis, and in most cases surgery, but before radiotherapy or chemotherapy. Each participating patient completed a Health Utilities Index (HUI) Mark 2 (HUI2) and Mark 3 (HUI3) 15-item self-complete questionnaire, prior to encounter with assessing physician. The assessing physician, blind to patient's assessment, recorded a Karnofsky Performance Score (KPS) and a Mini-Mental Status Examination (MMSE) score. The life status for each patient was determined for the five-year period after assessment. Proportional hazards models estimated the IHOD for differences of: 0.10 in HUI utility scores; ten units in KPS; and five units in MMSE. Statistical significance was set at the 5% level.

**RESULTS:** HUI2 self-care was the only health status measure associated with a significant IHOD for LG tumors (n = 25): a decrease of 0.10 in HUI2 self-care score being associated with a 30% IHOD (p = 0.023). Among patients with HG tumors (n = 56), 3 measures were independently significant: KPS (20% IHOD, p = 0.022); MMSE (26% IHOD, p = 0.015) and HUI3 dexterity (18% IHOD, p = 0.035). Two measures, together, were significant among HG patients: MMSE (29% IHOD, p = 0.007) and HUI3 dexterity (20% IHOD, p = 0.020). **CONCLUSION:** Only HUI measures were significant predictors of IHOD for both LG and HG patients. MMSE and HUI3 dexterity, in combination, were significant predictors for HG patients. The latter is evidence that patient- and physician-reported measures provide important complementary types of information.

**PCN28**

**REVIEW OF ECONOMIC APPRAISALS OF CHEMOTHERAPY FOR METASTATIC COLORECTAL CANCER**

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**OBJECTIVES:** To assess economic appraisals of chemotherapy regimens for metastatic colorectal cancer (mCRC) published in peer-reviewed journals. **METHODS:** A PubMed search of English-language documents published up to October 2004 was conducted using the search terms: "chemotherapy", "metastatic", "colorectal cancer", and "economic", "cost-effectiveness", or "cost-benefit". Additional publications were identified from references, reviews, and meta-analyses. Publications were reviewed for information on the type of cost analyses, year of publication, journal, country, perspective, type of chemotherapy assessed, data collection methods, sponsorship, and types of sensitivity analyses conducted. **RESULTS:** Economic analyses were published on eight regimens. Seven of the 14 published studies were published from a UK perspective, and 2 each from a French and a Dutch perspective; no study has been published from the US perspective. Ten studies were cost-consequences and four were cost-effectiveness analyses. Limited documentation was provided on sources of costs for medical resource use. Adjustments for quality of life were considered in sensitivity analyses in two studies designed to inform guidance by the UK's National Institute of Clinical Excellence. Overall, drug costs accounted for 1%–37% of total expenditures for 5-flourauracil + leucovorin (5FU/LV) regimens, in contrast to 47%–83% of total expenditures for newer combination regimens (e.g., irinotecan + 5FU/LV, oxaliplatin +5FU/LV, capecitabine). No formal analyses were published on Avastin (bevacizumab) or Erbitux (cetuximab). Discounting for future costs and benefits was not done in any analysis. **CONCLUSIONS:** Some prominent novel regimens for mCRC have no publicly available economic appraisal. Among the few published studies on older regimens, most omit components such as quality-of-life adjustments, discounting, and transparent statements on data sources for prices that are recommended in ISPOR's statement on "Good Research Practices—Modeling Studies."

**PCN29**

**GAPS IN THE ECONOMIC EVALUATION OF PROSTATE CANCER**

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**OBJECTIVE:** This study seeks to synthesize and identify gaps in the economic literature of prostate cancer (PCA). **METHODS:** English-language abstracts and articles published between 1990