

risk thresholds (FNRTs) for primary prophylaxis with CSFs.

OBJECTIVES: To determine the impact of CPMs on FNRT estimates with the CSFs.

METHODS: Cost-minimization models based on standard decision theory were generated, incorporating 1) probabilities and resource utilization from randomized clinical trials and 2) unit cost information from local institutional sources. Sensitivity analyses were performed, varying resource use, costs, and test performance characteristics. FNRTs were derived at which cost equivalence was reached in each model. The test performance of possible CPMs was assessed utilizing the likelihood ratio (LR) for discriminating high-risk patients with probability (prob[HR]).

RESULTS: Baseline cost-minimization models were equated with CPMs with a LR = 1.0. The FNRT for CSF use decreases as hospitalization length of stay (LOS) or cost/day increase. Any CPM associated with a LR+ > 1 generates lower FNRTs than under baseline conditions. Test efficiency of the CPMs improves with increasing LR+, with optimal performance observed between 2.0 and 4.0. In balanced CPMs with LR+ = 3.0, FNRTs are reached for costs/day of \$1000, \$1500, and \$2000 at 0.21, 0.16, and 0.13 respectively. In unbalanced CPMs, FNRTs are <10% at prob(HR) = 0.4, 0.3, 0.2, and 0.1 at costs/day of \$1700, \$1000, \$600, and \$300, respectively.

CONCLUSIONS: Efficient CPMs to identify high-risk patients should be able to further reduce costs and FNRTs for CSF use based on cost-minimization.

PCA9

QUALITY OF LIFE (QOL) OF PATIENTS WITH LOW-GRADE NON-HODGKIN'S LYMPHOMA (IG-NHL) TREATED WITH FLUDARABINE (F) OR CYCLOPHOSPHAMIDE-VINCRIStINE-PREDNISONE (CVP)

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OBJECTIVE: To evaluate the QoL of Ig-NHL patients enrolled in a trial comparing the efficacy and safety of F and CVP.

METHODS: The EORTC-QLQ-C30 (v1) questionnaire was completed by all French- and English-literate patients at baseline, during treatment, and after treatment. QoL was expressed as a global health status (QL) and five functional scores (FS); physical, emotional, social (SF), cognitive (CF) and role (RF), for which high values indicate better QoL. It was also expressed as eight symptom/single item (SSI) scores: fatigue, nausea, and vomiting (NV), pain, dyspnea (DY), insomnia, appetite loss, constipation (CO), diarrhea (DI), and financial difficulties (FI) for which lower values mean better QoL.

RESULTS: Of the 91 patients recruited (F = 47, CVP = 44), 84 completed the questionnaire at baseline, 74 during treatment, and 41 after treatment. All FS were high at baseline (70–90) and varied from 1 to 12 points during the study. All FS improved during treatment except CF and QL in the F group, which remained unchanged; and RF and SF in the CVP group, which deteriorated. The difference between groups reached statistical significance for SF (p = 0.0076) but not for RF (p = 0.4597). All SSI scores were low (10 to 40) and varied only slightly during the trial. Most scores improved except DY and CO in the F group and NV, CO, DI, and FI in the CVP group.

CONCLUSIONS: QoL was high in these patients. The higher incidence of nausea, vomiting, and alopecia observed in the CVP group may explain the difference observed for SF, and, to a lesser extent, RF.

PCA10

THE RELATIONSHIP BETWEEN PROFILE-BASED QUALITY OF LIFE SCORES AND EUROQOL-5D SCORES IN BREAST CANCER SURGERY PATIENTS

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OBJECTIVE: The objective of this study was to determine the relationship between profile-based cancer-specific quality of life dimension scores, and EuroQol-5D scores in a breast cancer surgery sample.

METHODS: Seventy-five breast cancer surgery patients participated in the study. The patients completed the Functional Living Index-Cancer (FLIC), the Functional Assessment of Cancer Therapy-General Version (FACT-G), and the EuroQol-5D (EQ-5D) at the same visit, and the order of instruments was randomized. Scores on both the EQ-5D classification system, as well as on the thermometer, were obtained, and both scores were related to dimension scores on the FLIC and the FACT-G. Information on the age of the patient, the cancer stage, and the number of comorbidities was obtained through chart review.

RESULTS: The mean age of patients was 60 (SD = 10.7). The majority of patients (96%) were diagnosed with either stage I or stage II breast cancer. Over 90% of patients had up to three comorbid conditions, with hypertension being the most frequent. Mean scores on the EQ-5D classification system and the thermometer were 87.4 (SD = 13.6), and 86.6 (SD = 12.6), respectively. Ceiling effects were observed on the classification system as well as the thermometer. Both linear and double log regression results showed that quality of life dimension scores were significantly related to scores in both the EQ-5D classification systems and the thermometer. FLIC dimension scores made statistically significant contributions to the EQ-5D classification score, but not to the score obtained on the thermometer. FACT-G dimension scores did not contribute significantly to either the EQ-5D classification score or to the thermometer score.

CONCLUSION: The results of this study show that can-