SESSION II

METHODOLOGY ISSUES

FROM HEALTH-RELATED QOL TO UTILITY—IS THERE A WAY?
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OBJECTIVE: To predict utility values from health-related quality of life (HRQL) assessments could, if possible, be a fruitful way to use HRQL assessments for health economic evaluations. With this in mind, we compared values for SF-6D, an index derived from the domain values of SF-36 by an algorithm from Brazier et al., with values from the EuroQol instrument, the EQ-5D index, and the EQ-VAS (Visual Analog Scale).

METHODS: Data from two surveys of patients with respiratory disease were used in this comparison. The first data set was from 120 patients in the northern part of Sweden with COPD, and the other data set from 206 patients in Hungary suffering from asthma. Both surveys covered patients with different severity of the disease. The two datasets were analyzed separately. The EQ-VAS values were rescaled from a range of 0–100 to a 0–1 range.

RESULTS: Results are consistent for the two different data sets and shows an expected gradient for severity groups in both cases. SF-6D has on the average slightly lower values than EQ-5D but higher than EQ-VAS (Mean for COPD: 0.74 vs 0.78 and 0.65; ASThma: 0.69 vs. 0.70 and 0.62). On the other hand, both EQ-5D and EQ-VAS have larger variation with a substantial proportion of patients reaching maximum or minimum achievable values. Correlations between the different indices are deceptively high because of extreme values (r for COPD: 0.75–0.69; ASThma: 0.70–0.49).

CONCLUSION: SF-6D shows a response pattern more in line with intuitive expectation than EQ-5D and EQ-VAS, which both seem to have a ceiling (and floor) problem.

ESTIMATING PREVALENCE AND SURVIVAL BY STAGE OF CANCER FROM THE US SEER DATABASE: COLORECTAL CANCER
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OBJECTIVE: To understand disease burden, prognosis, and survival, and estimate target patient populations for treatment, knowing the prevalence of patients by their clinical stage of disease (AJCC/UICC/TNM) is important. However, such data is not readily available in the published SEER (Surveillance, Epidemiology and End Results) statistics. Moreover, the SEER definitions for staging cancer into local, regional, and distant has changed from 1973–98, and do not coincide with the AJCC clinical stages of I, II, III, and IV. The latter has also undergone five editions from 1978–1997. Colorectal cancer is the third most common incident cancer in the US, with good prognosis and survival if detected early. We estimated the prevalence and survival of colorectal cancer by clinical stage.

METHODS: From the August 2001 release of the SEER database, there were 281,940 cases with a diagnosis of colorectal cancer and complete follow-up through December 31, 1998. The different staging systems of AJCC, TNM, SEER 2000, SEER Historic Coding, and Dukes/Astler-Collins were summarized and compared, showing the differences and the overlap in the staging systems. Colorectal cancer cases diagnosed from 1988–1998 (n = 129,664) were recoded to the AJCC coding system by SEER. In order to estimate age-adjusted prevalence by stage for the year 2001, we calculated the 1998 age specific prevalence. This latter figure was standardized to the 1990 US standard population to estimate the age-adjusted prevalence, which was then projected onto the 2001 US population estimates to calculate an estimated age-adjusted prevalence in 2001 by stage of disease.

RESULTS: The estimated year 2001 prevalence of colorectal cancer and median survival by AJCC stage were: Stage I, n = 228,958, 9.7yrs.; Stage II, n = 223,936, 6.7yrs.; Stage III, n = 145,307, 3.9yrs.; and Stage IV, n = 28,009, 0.8yrs.

CONCLUSION: Colorectal cancer in the US was found to have decreasing prevalence and survival with increasing clinical stage (severity).

DEVELOPMENT OF DESCRIPTIONS OF TREATMENTS FOR COLORECTAL CANCER FOR USE IN PREFERENCE MEASUREMENT
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OBJECTIVE: When using non-patients as respondents in health state preference measurement, it is necessary to develop accurate descriptions of treatment alternatives and health states patients may be likely to experience. We developed descriptions of commonly used treatment modalities for colorectal cancer (CRC) and ensuing health states for use in subsequent preference measurement studies.

METHODS: Following a literature review and clinical expert input, we identified four commonly used treatment modalities for CRC. Clinical data for each of the modalities were abstracted from the literature, and reviewed by