in the USA in 2002. Inpatient care costs accounted for more than 60% of total cost. Low-income patients (74.8%) of treated patients received combination therapy with platinum-based agents. Of 1,221 patients treated with platinum-based combination therapy, the most therapy commonly used includes gemcitabine (37.5%), taxanes (21.5%), and vinorelbine (18.2%), while 21.4% of patients received two or more other agents. We observed longer median overall survival in patients with one regimen of chemotherapy agents received. CONCLUSIONS: Lung cancer patients in Taiwan incurred considerable health care costs after diagnosis. More than half of patients were treated with chemotherapy, in particular with multiple chemotherapy agents. Future research comparing cost-effectiveness among different treatment options is warranted.

PCN71 AUSTRALIAN STANDARD COSTS AND CONSEQUENCES OF FOUR CHEMOTHERAPY ADVERSE EVENTS

OBJECTIVES: This work aimed to develop rigorous models of the Australian costs of four common chemotherapy adverse event (diarrhoea, vomiting, anaemia and neutropenia) associated with VTE in cancer patients.

METHODS: Decision analytic modelling was used to identify the costs and consequences of AEs. These are not only stand alone models, but also form decision tree sections to be incorporated into larger models of chemotherapy cost effectiveness. Model structures are based on best-practice clinical pathways, and incorporate efficacy of side effect treatment, quality of life and chemotherapy dose. Literature reviews identified clinical inputs. Costs of treatment were retrieved from relevant Australian sources such as the Pharmaceutical Benefits Schedule. The perspective was the Australian health care system. One-way sensitivity analyses explored uncertainty in the models. RESULTS: The base case average cost per chemotherapy patient was $417 (1st AE) to $2,450 (5th AE); for those whose regimen included a 1st AE and whose regimen included a 2nd AE intervention (Table 1). Neutropenia base case costs ranged from $2.23 (outpatient management) to $12,054 (intensive care required). Where possible, the impact on quality of life and chemotherapy total dose was also modelled. Roughly 1% of the patients who were admitted to the hospital. These estimates appear consistent with studies of similar methodology. CONCLUSIONS: The four models presented represent best-practice modelling techniques for chemotherapy AEs. Each has been designed to enable the users to model the cost model to be incorporated into larger models of chemotherapy cost effectiveness. This allows model builders to incorporate rigorous, Australian-specific estimates of the costs and consequences of chemotherapy AEs into models of chemotherapy cost effectiveness.

PCN72 HORMONAL RECEPTOR POSITIVE, HER2 NEGATIVE METASTATIC BREAST CANCER (MBC) HR+HER2-: PRE AND POST-PROGRESSION COSTS UNDER THE PUBLIC HEALTH CARE SYSTEM (SUS) AND SOCIETAL PERSPECTIVES IN BRAZIL

OBJECTIVES: To estimate direct medical costs and productivity costs of hormonal receptor positive, HER2 negative metastatic breast cancer (MBC HR+HER2-) under the public health system (SUS) and societal perspective in Brazil. The perspective chosen was the Cost of Healthcare Induced FN within the context of the Irish Health care setting. The bootstrap estimation was used to identify the costs and consequences of AEs. These are not only stand alone models, but also form decision tree sections to be incorporated into larger models of chemotherapy cost effectiveness. Model structures are based on best-practice clinical pathways, and incorporate efficacy of side effect treatment, quality of life and chemotherapy dose. Literature reviews identified clinical inputs. Costs of treatment were retrieved from relevant Australian sources such as the Pharmaceutical Benefits Schedule. The perspective was the Australian health care system. One-way sensitivity analyses explored uncertainty in the models. RESULTS: The base case average cost per chemotherapy patient was $417 (1st AE) to $2,450 (5th AE); for those whose regimen included a 1st AE and whose regimen included a 2nd AE intervention (Table 1). Neutropenia base case costs ranged from $2.23 (outpatient management) to $12,054 (intensive care required). Where possible, the impact on quality of life and chemotherapy total dose was also modelled. Roughly 1% of the patients who were admitted to the hospital. These estimates appear consistent with studies of similar methodology. CONCLUSIONS: The four models presented represent best-practice modelling techniques for chemotherapy AEs. Each has been designed to enable the users to model the cost model to be incorporated into larger models of chemotherapy cost effectiveness. This allows model builders to incorporate rigorous, Australian-specific estimates of the costs and consequences of chemotherapy AEs into models of chemotherapy cost effectiveness.