tion of the Centre’s activities, for each modality of patient follow-up and treatment (surgery, radiotherapy, chemotherapy, consultations). Unit costs were obtained from cost accounts of the Centre. Medical cost of breast cancer was computed from the cancer-centre perspective, by adding micro-costing and macro-costing components.

RESULTS: The mean medical cost per patient was €10,072 [95% CI 9,195; 10,948]. Costs per patient ranged from €2,813 to €36,170. Median cost was of €8,860. The initial treatment phase represented the most expensive component, reaching €7,378 [7,040; 7,717] on average, which amounted to 73.3% of the global cost.

CONCLUSION: This study has provided an estimate of the global cost of managing patients with breast cancer in a French Comprehensive Cancer Centre (CLCC). Our estimates were consistent with those of the French national database of costs per DRG. However, our approach has the advantage of providing a cost per patient suitable for cost-of-illness evaluations, rather than a cost per hospital stay.

OBJECTIVE: To compare the pharmacoeconomic results of a breast cancer treatment model for Japan using several criteria, including level of evidence of the clinical data.

METHODS: The Japanese Breast Cancer Treatment Model (JBCTM) features treatment pathways for four breast cancer stages. The model includes resources, costs, and clinical outcomes for all treatments, and has the ability to estimate the cost-effectiveness of treatments in various settings with consideration given to the level of evidence. Guidelines from the American Society of Clinical Oncology (ASCO) were used to stratify the clinical data for drug treatments in the model. The ASCO levels of evidence criteria are ranked from Level I, evidence from studies showing the highest level of clinical results supporting treatment usage, to Level V, those yielding the weakest evidence for usage. For the JBCTM, the ASCO definitions of Levels I and II were directly followed and Levels III through V were combined into one level. The model contains over 450 level-of-evidence references for more than 60 drug treatments. An example of an evaluation using the JBCTM is a cost-effectiveness analysis comparing one chemotherapy combination, CAF, to two other regimens, CEF and CMF in advanced breast cancer.

RESULTS: Although the incremental cost-effectiveness ratio for CAF compared to CEF is negative, indicating CAF is a dominant strategy, the clinical evidence is only Level II. In contrast, the incremental cost-effectiveness ratio for CAF compared to CMF is positive, although relatively low at 14,087€ for each percentage increase in objective response, but the clinical evidence is Level I, the highest possible.

CONCLUSIONS: Although the cost-effectiveness ratios show that CAF is more cost-effective when compared to CEF than when compared to CMF, the evidence level for choosing CAF over CMF is higher. Decision-makers can be more informed by considering both levels of evidence and pharmacoeconomic data.

OBJECTIVES: Hyperuricemia (HU) and tumour lysis syndrome (TLS) are important complications leading to morbidity and mortality in patients with haematologic malignancies. The objective was to assess the cost-effectiveness (CE), in terms of cost per life year saved (LYS), of preventing or treating HU and TLS with recombinant urate oxidase, rasburicase (FASTURTEC®).

METHODS: The current incidence and costs of HU and TLS were studied in a multi-country chart review including 788 adults and children treated for acute lymphoid or myeloid leukaemia (ALL or AML) or non-Hodgkin lymphoma (NHL). Costs, expressed in Euro, were calculated from the UK payer’s perspective. The average life expectancy at the time of diagnosis was based on cancer survival rates and age at diagnosis reported in the literature. Adult data were derived from the Eurocare study, childhood data from UK national statistics.

RESULTS: HU incidence was 18.9% and its average cost was 1,679€uro (SE = 519). TLS incidence was 5% and its average cost was 11,202€uro (SE = 2,147), and TLS-related mortality was 0.8%. With 90% reduction of HU and 100% reduction of TLS cases by rasburicase, the average CE of prevention in adults was 20,652€uro/LYS for ALL, 83,824€uro/LYS for AML and 31,667€uro/LYS for NHL. The high CE ratio in AML is explained by its low life expectancy. In children the respective results were only 379€uro/LYS, 668€uro/LYS, and 388€uro/LYS. Sensitivity analyses showed these results to be robust, especially in children. If applied only for treatment of established HU/TLS, rasburicase is associated with savings of 1,089 Euro in adults and 2,358 Euro in children, becoming cost-saving as of a 65% and only 24% reduction of TLS in adults and children respectively.

CONCLUSION: In prevention of HU/TLS, highly cost-effective results can be obtained in children, and reasonably cost-effective results in adults with ALL. Both in adults and children, treating HU with rasburicase would be a cost-saving intervention.