benefit of new treatments for BC is directly measurable at the national level.

**COST OF INITIAL PROSTATE CANCER TREATMENT FOLLOWING DIAGNOSIS PER PATIENT BY STAGE: ESTIMATES FROM THE UK, FRANCE, GERMANY, ITALY AND SPAIN**

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**OBJECTIVES:** To calculate the total per patient cost of prostate cancer (PCa) treatment by stage in the 1st year following diagnosis in 5 European countries. **METHODS:** IMS Oncology Analyzer (OA), a survey-based data collected from urologists, radiologists, and oncologists between 2002–2006 provided data on diagnostic interventions and initial treatment for 10,576 patients treated in hospitals for UK, Germany, France, Italy and Spain. A costing model combined the data with local expert opinion and published data on resource use and unit costs from published sources to calculate total per patient costs by stage. Diagnostic costs, first surgery, radio- and chemotherapy costs, if any, were included. Cost of 1st-line hormonal therapy, with possibly was also included. Relapse and mortality was factored into the model. Total direct medical costs of initial treatments following diagnosis per patient were calculated for all stages. **RESULTS:** Majority of men across countries were diagnosed in Stage II. As initial treatment following diagnosis, across all stages, radiation therapy (EBT + brachytherapy) was used most frequently across countries, ranging from 42% (France) to 21.5% (Germany). Use of chemotherapy was low. Total per patient direct costs following diagnosis averaging all stages were €4057, €3256 €3171 (exchange rate conversion), €5226 and €5851 for Germany, Spain, UK, Italy and France, respectively. Surgeries were the largest cost component in all countries except for the UK and Germany. In Germany hormone therapy represents a similar cost to surgery; in the UK where radiation therapy had the highest cost proportion. **CONCLUSIONS:** In this first study quantifying the cost of PCa treatment in five European countries using similar methods and source across countries found similar total per patient cost estimates, although different treatment patterns and types of costs by country. Given the number of new cases diagnosed in Europe, these estimates suggest a large total spending on the disease.

**YEARS OF POTENTIAL LIFE LOST AND PRODUCTIVITY COSTS DUE TO CANCER MORTALITY AND FOR SPECIFIC CANCER SITES WHERE HPV MAY BE A RISK FACTOR FOR CARCINOCENESIS—UNITED STATES, 2003**

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**OBJECTIVES:** Although years of potential life lost (YPLL) and mortality-related productivity costs comprise a substantial portion of the burden of cancers where HPV may be a risk factor for carcinogenesis (henceforth called HPV-associated cancers), estimates of these costs are limited. We estimated the mortality-related burden (in terms of YPLL and productivity costs) of HPV-associated cancers and all malignant cancers in the United States in 2003. **METHODS:** We used 2003 national mortality data and US life tables to estimate YPLL for HPV-associated cancers and all malignant cancers. YPLL was estimated by use of the life expectancy method. We used the human capital approach to estimate the value of the expected future lifetime productivity losses due to premature deaths from HPV-associated cancers and all malignant cancers. Indirect mortality costs were estimated as the product of the number of deaths and the expected value of individuals’ future earnings, including an imputed value of housekeeping services. **RESULTS:** In 2003, HPV-associated cancers accounted for 181,026 in YPLL, which represent 2.4% of the estimated 7.5 million YPLL attributable to all malignant cancers in the United States. The average number of YPLL was 21.8 per HPV-associated cancer death and 16.3 per death to overall malignant cancers. Overall, HPV-associated cancers had the largest relative contribution to YPLL in 30–34 year-old females. The lifetime productivity cost due to mortality in 2003 was $3.7 billion for HPV-associated cancer mortality and $133.5 billion for overall malignant cancer mortality. **CONCLUSIONS:** HPV-associated cancers impose a considerable burden in terms of premature deaths and productivity losses. Quantifying the burden of these HPV-associated cancers mortality in the population may provide useful information for understanding the full potential benefits of prevention efforts.

**PODUM SESSION III: INFECTIOUS DISEASE ECONOMIC EVALUATIONS**

**COST EFFECTIVENESS ANALYSIS OF REYATAZ® VERSUS KALETRA® IN THE TREATMENT OF NAIVE HIV PATIENTS IN ITALY**

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**OBJECTIVES:** To estimate the cost-effectiveness of Reyataz® versus Kaletra® in treatment-naive HIV-1 patients in Italy. **METHODS:** For this purpose a life time Markov model was developed with a cycle length of one year. The model included the following health states; 1st, 2nd and 3rd line treatment and within these treatment lines patients could suffer from an MI, stroke or angina. Treatment switch transition probabilities were derived from a 48 week randomized trial and event probabilities were derived from the Framingham risk equations and the 48 week trial. Diarrhea was included as a disutility. Variables that differed between the two treatment arms were pharmaceutical treatment costs, lipid profile, probability to switch 1st line treatment, mortality and incidence of diarrhea. The analysis was conducted from a third-party payer perspective. Direct costs inside the health care system were included. Outcomes were reported as cost per (quality adjusted) life year gained. To determine the robustness of the model and the impact of uncertainty, uni- and multivariate sensitivity analyses were carried out. **RESULTS:** In the base case analysis Reyataz® saved 0.07 [−0.50, 0.83] life years, 0.12 [−0.31, 0.85] QALYs and −€508 [−€888,264, €19,424] costs. The resulting ICER and ICUR were dominant for Reyataz®, e.g. cost saving and more effective. Probabilistic sensitivity analyses showed that Reyataz® has 0.80%, 16.70%, 10.30% and a 72.20% probability to be cost-effective at a WTP of €20,000. The univariate sensitivity analysis showed that the results were especially sensitive to changes in the cost of second and third line treatment and switching treatment probabilities. **CONCLUSIONS:** The present model suggests that Reyataz® has a favourable cost-effective ratio in the treatment of treatment naive HIV-1 patients. Sensitivity analysis showed that these results were stable.