health impact of letrozole is of interest to health care systems. Our objective is to estimate the budget and health impact of adding letrozole to a US managed care formulary. **METHODS:** Estimates of increased time on first-line, second-line, and third-line hormone therapy were based on clinical trial data for letrozole. These parameter values, along with demographic, epidemiologic, and market share data for a hypothetical managed care organization in the US with 1,000,000 covered lives were entered into an interactive EXCEL spreadsheet model. Outcomes included total annual health plan costs for hormone therapy and for treatment of advanced breast cancer with and without letrozole; per member per month increases in costs associated with letrozole on the formulary; and a proxy measure for life expectancy gain with letrozole on the formulary, increase in average time on hormone therapy. Input parameter values could be changed in the model to capture site-specific characteristics. **RESULTS:** The average duration of first-line therapy was 16.5 months with letrozole compared to 11.9 months with tamoxifen based on the clinical trial data. Assuming market share of 25% for letrozole as first-line hormone therapy, 37% for second-line, and 20.5% for third-line, the increase in per-member, per-month costs of adding letrozole to the formulary was $0.006 and the increase cost per treated member per month was $8.37. The life expectancy benefits with letrozole included in the formulary were estimated as an increase of 2.7 months on hormone therapy per woman starting endocrine therapy. **CONCLUSIONS:** Adding letrozole to a managed formulary results in significant health benefits at a very low increase per member per month cost (less than $0.01).

**ECONOMIC BURDEN OF ACTINIC KERATOSIS AND SQUAMOUS CELL CARCINOMA IN AMBULATORY CARE**

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**OBJECTIVES:** The purpose of the study was to estimate the economic burden in ambulatory care of actinic keratosis (AK) and its progressive state squamous cell carcinoma (SCC) noninvasive, and invasive or metastasized SCC. **METHODS:** prevalence study for 1998 of all costs associated with the treatment of these cases using the National Ambulatory Medical Care Survey and an administrative claims database from selected plans from a national health care company was conducted. An expert panel of dermatology and oncology specialists was used to develop reference cases reflecting the different treatment protocols for AK and nonmelanoma skin cancers. These reference cases were used for case identification and claims extraction as related to treatment pattern for each disease state. The resulting analytical file was then used to calculate the economic burden of illness. The data show that the number of visits and the cost per visit increases with age. **RESULTS:** The total ambulatory care costs for AK, SCC and basal cell carcinoma (BCC) combined exceed $2.4 billion/year. AK, SCC and BCC are responsible for over 3 million office visits annually. AK patients average 2.31 visits/year and SCC/BCC patients average 2.84 visits/year. SCC and BCC share the same ICD-9-CM diagnosis code, although different in etiology. BCC has no known precursor lesions while SCC presents a progressive state of AK. Assuming conservatively that the per visit costs for BCC and SCC are the same and that 30% of all BCC/SCC cases are SCC, we estimate that the total ambulatory care costs of AK and its sequel SCC exceed $1.1 billion/year. These costs are ambulatory costs only, and do not include outpatient or inpatient treatment. **CONCLUSIONS:** Ambulatory care spending on AK and SCC is substantial and poses a significant economic burden.

**PHARMAECOENOMICAL ANALYSIS OF UNFRACTIONATED HEPARIN VERSUS DALTEPARIN IN PATIENTS WITH MALIGNACIES**

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**OBJECTIVE:** To perform pharmacoeconomical analysis of unfractionated heparin (UFH) versus dalteparin (D) for thrombosis prevention in patients with malignancies. **METHODS:** Randomized open pharmacoeconomical study included 99 patients after operative involvement for cancer of stomach or bowels: 50 in D group and 49 in UFH group. The efficiency of studied drugs was assessed by monitoring soluble fibrin monomeric complexes (SFMC) in blood serum that was considered to be a prognostic factor for thromboembolism. Costs included direct medical expenditures for hospital treatment from payer's perspective. **RESULTS:** Both drugs significantly reduced SFMC after operation, but patients in D group had significantly more expressed decrease in the level of SFMC, than in UFH group ($\delta = 0.003$). In UFH group vs D group costs for medicines per patient for period of treatment were significantly less (median cost 2849.4 rub. vs. 6066.4 rub.; $\delta = 0.000$) but costs for medical services were significantly higher (median 21,770.0 and 19,765.0 rub.; $\delta = 0.012$), mainly because of more subcutaneous injections per day. **CONCLUSION:** D therapy leads to significantly more expressed decrease in SFMC level than UFH in cancer patients. At the same time costs per treatment are equal because high expenditures for drugs are compensated by less expenditures for injections. So D is a reasonable alternative to traditional UFH therapy.