found in the literature (min 22.90%, max 42.80%), treatment with starting dose DA 500 mg Q3W resulted in a BI that were 35.64% and 27.64% lower than EPOalfa 10,000 UI ITIW and 40,000 UI QW respectively and 35.59% and 17.11% lower than EPObeta 10,000 UI ITIW and 30,000 UI QW respectively. The results of the base case did not change in any of the sensitivity scenarios. CONCLUSION: The model shows that treatment of CIA with starting dose DA 500 mg Q3W is the rapaceutic strategy with lower mean cost per patient for all the analyzed scenarios in Spain.

HEXVIX FLUORESCENCE CYSTOSCOPY FOR SUPERFICIAL BLADDER CANCER DIAGNOSIS: ANALYSIS OF BUDGET IMPACT ON THE SWEDISH HEALTH SERVICE

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OBJECTIVE: Development of a decision analytic model to estimate the budget impact on the Swedish health service of using a more effective diagnostic tool in conjunction with white light cystoscopy (WLC) in the management of superficial bladder cancer (SBC). Hexvix (hexaminolevulinate) fluorescence cystoscopy potentially allows more complete detection and delineation of tumours compared with WLC in bladder cancer diagnosis. METHODS: Model inputs, including procedure costs and clinical algorithms, are based on the bladder cancer diagnosis and treatment guidelines of the European Association of Urology (EAU), literature review and Swedish clinical practice. Several trials report less residual tumour at early re-resection following 5-ALA fluorescence-assisted TURB with 59% to 80% relative reduction in recurrence in the fluorescence group compared to WLC. Based on these findings, the model assumed a conservative reduction in recurrence in the fluorescence group compared to WLC. The model projects the flow of all newly diagnosed SBC patients, following histological risk classification at first TURB, through treatment one year after diagnosis. It covers Hexvix use in the operating room to guide first TURB in all patients with suspicion of bladder cancer and all follow-up TURBs in patients with recurrent SBC. RESULTS: In the Swedish population of newly diagnosed bladder cancer patients, the model projects a reduction in the number of procedures required in the first year compared to WLC alone, i.e. 29 cystectomies and 1961 TURBs with Hexvix compared to 52 and 2141 with WLC. Avoidance of these procedures would result in €2423 pegfilgrastim versus €4275 filgrastim. Pegfilgrastim reduced the absolute risk of FN by 5.5% (12.5% versus 7%) and had a LYG of 0.06 (16.48 versus 16.42 years). Age of diagnosis and cancer stage had minimal impact on the results. Key influencing factors included drug costs, relative risk of FN, and drug administration cost. CONCLUSION: Primary prophylaxis with pegfilgrastim in Spain appeared not only to be more effective but also cost-saving compared with filgrastim used for 11 days per cycle.

PCNS

IMPACT OF CHANGES IN THE FINANCING OF THE HEALTH SERVICES ON COSTS STRUCTURE ON THE EXAMPLE OF CHEMOTHERAPY OF ADVANCED OVARIAN CANCER

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In 2002, the medical services in Poland has been paid by the independent public insurance institutions—Regional Cash of Ills. In 2003 the government established The National Fund of Health, which integrate all regional insurance institutions and provide identical availability of medical services for every patient in Poland. OBJECTIVES: To assess the impact of changes in financing of health services on costs structure from the payer perspectives on the example of advanced ovarian cancer. METHODS: Two regimens of chemotherapy were assessed: cisplatin-cyclophosphamide (CC) and cisplatin-paclitaxel (CP). The data of medical resources consumed were collected retrospectively in two oncology centers in Poland. All medical care consumption (diagnostic tests, hospitalization, ambulatory care and medications) were estimated from the patients’ chart. Costs were derived from the hospitals’ Financial Departments for the year 2002. And from the system used by National Fund of Health for 2006. All cost were in polish zloty. RESULTS: The total cost of chemotherapy per patient in CP group in 2002 were 21,658 zł and in 2006—14,594 zł, while the standard chemotherapy with CC scheme were 9008 zł in 2002 and 6000 zł in 2006. All cost were in polish zloty. In 2002—51% of total costs was in CC group the 72,5% of the total cost were the cost of chemotherapy per patient in CP group in 2002 were 21,658 zł and in 2006—14,594 zł, while the standard chemotherapy with CC scheme were 9008 zł in 2002 and 6000 zł in 2006. All cost were in polish zloty. In 2002—51% of total costs was the cost of hospitalization. CONCLUSIONS: The changes in financing of the health system decreased the total costs of ovarian cancer chemotherapy. The main reason of it in PC group could

PCN6

PRIMARY PROPHYLAXIS WITH PEGFILGRASTIM IS COST-SAVING COMPARED WITH FILGRASTIM FOR BREAST CANCER IN SPAIN

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OBJECTIVES: Primary (first-cycle) prophylaxis with filgrastim or second generation pegfilgrastim has been recommended in the 2006 ASCO and EORTC clinical guidelines when the risk of febrile neutropenia (FN) is >20%. Recent studies reported significantly greater reduction of FN with pegfilgrastim than with filgrastim, yet no study has compared their cost-effectiveness. The study purpose was to evaluate the cost-effectiveness of primary prophylaxis with pegfilgrastim versus 11-day use of filgrastim (as recommended) in women with stage I-III breast cancer receiving chemotherapy with moderate to high risk of FN in Spain. METHODS: We constructed a decision-analytic model from a health care payer’s perspective. Costs included costs for drugs, drug administration, FN-related hospitalizations and subsequent care, and were based on ex-factory price listing and literature. Effectiveness was measured as FN avoided and lifetime-gained (LYG). FN risk (varied by days of filgrastim), FN case-fatality, relative dose intensity (RDI), and the impact of RDI on survival were based on a comprehensive literature review and expert panel validation. Breast cancer mortality and all-cause mortality were from national cancer registries and vital statistics report. Sensitivity analyses were conducted on key variables. RESULTS: In addition to being more effective, pegfilgrastim primary prophylaxis produced an average cost-savings of €32 per patient (€4243 pegfilgrastim versus €4275 filgrastim). Pegfilgrastim reduced the absolute risk of FN by 5.5% (12.5% versus 7%) and had a LYG of 0.06 (16.48 versus 16.42 years). Age of diagnosis and cancer stage had minimal impact on the results. Key influencing factors included drug costs, relative risk of FN, and drug administration cost. CONCLUSION: Primary prophylaxis with pegfilgrastim in Spain appeared not only to be more effective but also cost-saving compared with filgrastim used for 11 days per cycle.
be the registration of generic of paclitaxel in Poland. While the changes in the cost structure in CC group could be produced by including the costs of additional medication into the cost of hospitalization.

**PCN8**

**RISE OF HEALTH RESOURCE UTILIZATION AND COSTS FOR SEQUENTIAL DOCETAXEL IN NODE-POSITIVE PRIMARY BREAST CANCER IN GERMAN HOSPITALS**

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**OBJECTIVE:** The introduction of DRGs in 2004 requires German hospitals to gain cost transparency and optimize budget allocation. We compared two different chemo regimens (4x EC followed by 4x docetaxel q21, EC→DOC vs. 6x CMF, day 1 + 8, q28) for patients with node positive primary breast cancer regarding costs of resource consumption. **METHODS:** Data were obtained piggyback during 2/2000–5/2002 on the German prospective, longitudinal, randomized, multicenter Phase III EC→DOC trial closed in 8/2005. Evaluation of diagnostic effort was based on a comprehensive monocentric retrospective chart review. To allocate costs to health care resources German tariffs in €2005 and hospital databases were used. Costs were presented from hospital provider perspective. Sensitivity and scenario analyses were conducted. **RESULTS:** Altogether a cohort of 110 patients who received 1047 cycle days at 38 study centers was analyzed. The average patient age was 52.4 years. Mean direct costs for EC→DOC group totaled €8,459 per patient (N = 54). Costs for cytostatics accounted for the largest portion with €5,673 (67%), staff costs for drug application and pharmacy services including transport averaged out €1,357 (16%), average hospital basic costs were €414 (4.9%) and €376 (4.4%) for diagnostic effort and port or catheter implantation. Hospitals spent €354 (4.2%) on supportive drugs, administration devices and infusion bags and €313 (3.7%) on rehospitalisation (8 times in 7 patients). In contrast to rather expensive EC→DOC, CMF was €3,486 less costly (−41.2%), but savings for CMF acquisition cost with −€5,598 were partially compensated by higher costs for medical and diagnostic effort or hospital hotel services. Results were most sensitive to docetaxel acquisition cost and the percentage of patients with incomplete chemotherapy. **CONCLUSION:** Our results will enable German hospitals to develop strategies of financing a consequential 70% budget increase caused by introducing sequential docetaxel in adjuvant chemotherapy of breast cancer.

**PCN10**

**INCREMENTAL COST-EFFECTIVENESS RATIO OF DARBEPOETIN ALFA (ARANESP®) IN THE TREATMENT OF CHEMOTHERAPY-INDUCED ANEMIA IN LUNG CANCER PATIENTS**

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Even if the clinical efficacy of recombinant human erythropoietin on chemotherapy-induced anemia was demonstrated, most economic studies have given unfavorable results, whatever the design and the outcome considered. **OBJECTIVE:** To calculate the incremental cost-effectiveness ratio (ICER) of darbepoetin alfa (Aranesp) as compared to standard palliative care in a cohort of patients treated by chemotherapy for lung cancer in clinical practice. **METHOD:** A Markov model was constructed to evaluate the cost effectiveness ratio of one weekly injection darbepoetin (Aranesp) compared with palliative standard care (red blood transfusion if hgb <8g/dl) in the correction of chemotherapy-induced anemia. Baseline probabilities and consumed resources were calculated on the basis of a two-year retrospective study, comparing two cohorts of patients treated by chemotherapy who received (n = 94) or did not receive (n = 89) Aranesp. The incremental cost-effectiveness ratio (ICER) was calculated as the difference in direct costs from a health care perspective (transfusion requirement and anemia management costs) divided by the difference in effect (changes in haemoglobin levels). Sensitivity analysis was used to test uncertain data. **RESULTS:** The use of Aranesp significantly reduced the proportion of patients needing transfusions (from 33.6% to 19.1%, p < 0.05) and the number of red cell units used by transfusion (from 2.97 ± 1.47 to 2.11 ± 0.47, p < 0.01). Markov modeling showed that the Aranesp strategy significantly increased the mean Hb level (13 ± 0.5 vs 11.9 ± 1 g/dl, p < 0.001), at the price of an increase in the main cost (respectively 1732 ± 897 and 996 ± 6436, p < 0.01). The incremental cost-effectiveness ratio was estimated to be 202€ per haemoglobin gram gained. Sensitivity analysis showed that the Aranesp strategy remained dominant in most situations. **CONCLUSION:** Routine use of Aranesp