than FACT-F. PQ could be helpful in monitoring cancer patients from clinical research or practice.

**PCN69**

PATIENT-REPORTED IMPAIRMENT OF EUROQOL HEALTH STATES AND PREFERENCE-WEIGHTED UTILITY IN ADVANCED RENAL CELL CARCINOMA IN A RECENT CLINICAL TRIAL

Mallick R1, Sun S1, Hudes G2

1Wyeth Research, Collegeville, PA, USA; 2Fox Chase Cancer Center, Philadelphia, PA, USA

OBJECTIVES: To evaluate patient-reported impairment in health states from the EuroQol (EQ-5D) assessment and derive UK preference-weighted utilities during periods of disease progression (PROG), toxicity (TOX), and time without symptoms of progression or toxicity (TWiST), based on a recent phase 3, randomized, outpatient study of first-line treatment of poor-prognosis patients with advanced renal cell carcinoma (RCC) randomized to temsirolimus, interferon, or interferon-temsirolimus. METHODS: In the clinical study, the EQ-5D was assessed at baseline, week 12, and week 32, at each grade 3 or 4 adverse event (AE), at study discontinuation, and at study end. Assessments were classified by their timing into 3 distinct periods: TOX (during grade 3 or 4 AEs or AE-related study discontinuation), PROG (during progression/relapse), and TWiST (during neither progression nor toxicity). Published UK-population preference weights were applied to patient-reported impairments on the EQ-5D domains—mobility, self-care, usual activities, pain/discomfort, and anxiety/depression—to derive utility values, consistent with EQ-5D methodology (euroqol.org). Median utility scores were compared across the periods of TOX, PROG, and TWiST. The proportion of patients reporting at least one EQ-5D domain at the highest level of severity was compared across the 3 periods, using the chi-square test. RESULTS: EQ-5D response rates were 87% (260/300) during PROG, 40% (230/570) during TOX, and 99% (278/279) during TWiST. Median utility values were 0.585 and 0.587 during TOX and PROG respectively, compared with 0.689 for the TWiST period (p < 0.0001). The proportion of patients with at least one of the EQ-5D domains at the highest level of severity was 34.2% (89/260) during PROG, 38.3% (88/230) during TOX, and 18.7% (52/278) during TWiST (p < 0.0001). CONCLUSION: Patients with advanced RCC reported similar impairment of EQ-5D domains during periods of toxicity and progression, significantly greater than in the absence of both; translating to corresponding differences in UK preference-weighted utility levels.

**PCN70**

UTILITY VALUES FOR HEALTH STATES FOR CHRONIC MYELOGENOUS LEUKAEMIA (CML): ESTIMATES FROM LAYPERSONS IN AUSTRALIA, THE UNITED KINGDOM (UK) AND CANADA

Levy AR1, Szabo SM1, Tabberer M1, Davis C1

1Oxford Outcomes Ltd, Vancouver, BC, Canada; 2Oxford Outcomes Ltd, Oxford, Oxon, UK; 3Bristol-Myers Squibb, Wallingford, CT, USA

OBJECTIVES: To estimate utility weights associated with CML-related health states among layperson respondents in three countries. METHODS: We elicited interviewer-administered time trade-off utilities with a 10-year time horizon for seven CML-related health states, from convenience samples of laypersons in Australia (n = 79), the UK (n = 100), and Canada (n = 103). Standardized health state descriptions were derived in consultation with a panel of oncologists. Interviewers underwent training and used a single script. Mean utilities with 95% confidence intervals (CI) were calculated for each health state. A generalized linear model was used to determine whether utilities, adjusted for age and sex, differed by country. RESULTS: The mean age of the combined sample was 46 years and 46% of respondents were men. Mean (95% confidence interval) utilities among Australian respondents were: 0.85 (0.81–0.89) for chronic responders (CR), 0.68 (0.63–0.72) for chronic non-responders (CNR), 0.71 (0.67–0.76) for accelerated responders (AR), 0.40 (0.34–0.45) for accelerated non-responders (ANR), 0.44 (0.38–0.49) for blast responders (BR), 0.12 (0.09–0.15) for blast non-responders (BNR), and 0.52 (0.45–0.59) for adverse events (AE). Utilities from UK respondents were: 0.90 (0.87–0.93; CR), 0.72 (0.67–0.77; CNR), 0.77 (0.73–0.82; AR), 0.53 (0.48–0.57; ANR), 0.55 (0.51–0.60; BR), 0.29 (0.24–0.34; BNR), and 0.32 (0.26–0.39; AE). Utilities from Canadian respondents were: 0.72 (0.66–0.77; CR), 0.56 (0.51–0.62; CNR), 0.58 (0.52–0.63; AR), 0.44 (0.39–0.49; ANR), 0.38 (0.34–0.43; BR), 0.26 (0.22–0.30; BNR), and 0.34 (0.28–0.39; AE). Significant differences were observed between and among countries. CONCLUSION: These data demonstrate the deteriorating impact on quality of life assigned to disease states occurring through progression of CML. This is one of the first studies to identify systematic differences between countries in utility weight estimates for oncological health states. This observation adds to evidence from other disease areas that systematic differences exist in utilities between countries.

**PCN71**

CONJOINT ANALYSIS A TECHNIQUE TO DEVELOP A QUESTIONNAIRE OF TREATMENT PREFERENCES IN PATIENTS WITH LUNG CANCER

Peruero N1, Cardenal P2, García R1, Juan O1, Vázquez S1, Barneto I1, Varela C2

1IMS Health, Barcelona, Spain; 2ICO. Hospital Duran i Reynals, L’Hospital de Llobregat, Barcelona, Spain; 3Hospital General Universitario Gregorio Marañón, Madrid, Spain; 4Hospital Arnau de Vilanova, Valencia, Spain; 5Complejo Hospitalario Xeral Calde, Lugo, Spain; 6Hospital General Universitario Reina Sofia, Córdoba, Spain; 7Roche Farma, Madrid, Spain

OBJECTIVES: To know which attributes related to treatment administration are valued highly in patients with lung cancer through the conjoint analysis. METHODS: A literature review was carried out to identify the attributes related to treatment. There were 6 attributes: Environment (E), Quantity (Q), Quality (Q), Treatment administration. Taking into account these attributes we elaborated 16 hypothetic scenarios. Through interviews with 2nd line lung cancer patients we asked them to order by preferred scenario. RESULTS: 24 patients were interviewed, with a mean (SD) age of 60.8 (11.6) years. 58.3% were men. The mean range of priority order, that is to say, of priority 1 (maximum preference) to priority 16 (minimum preference), we observed that the chosen scenarios in the first place were N (No time spent in the hospital/No immediate toxicity/Moderate symptom control). Quite a lot of confidence with the physician/More than 6 months survival/Oral administration) and H (Spending 2 hours per day at study end in the hospital/No immediate toxicity/Oroal administration) and J (No time spent in the hospital/High immediate toxicity/No symptom control).