Overall, the utility was higher for the PFS state than for baseline, but decreased below baseline in nonresponse and disease progression states. AEs had an important impact on utility within the PFS response state. The severe infection AE appeared to have a greater impact on patients responding to treatment compared to nonresponders, which may be related to the quality of life which is already low for the latter.

**PCN118**

**UTILITY VALUES FOR CHRONIC MYELOID LEUKAEMIA-CHRONIC PHASE (CML-CP) HEALTH STATES FROM THE GENERAL PUBLIC IN THE UNITED KINGDOM**

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OBJECTIVES: To estimate utility values associated with CML-CP health states among members of the public in the UK. METHODS: Interviewer administered time-trade off utilities were elicited for four CML-CP health states related to risk of progression, from a random sample of 241 members of the general public from eight cities across the UK, using health-state descriptions validated by clinicians and members of the general public. Mean utility values with 95% confidence intervals (CI) were calculated for each health state. RESULTS: The respondents’ mean age was 45 years and 51% were female. Seven percent (n = 18) of respondents had a cancer at the time of the interview which had been diagnosed for a mean 7.0 ± 6.5 years. The mean utilities with 95% CI were: 0.72 (0.69; 0.75) for untreated chronic phase CML; 0.80 (0.79; 0.82) for hematologic response, 0.89 (0.87; 0.90) for cytogenetic response, and 0.94 (0.94; 0.95) for molecular response. The utility values for each state are significantly different from one another (P < 0.001). The respondents’ preference values for any of the states were not significantly affected by their demographics or whether they had cancer. Nevertheless, the values elicited from respondents with cancer were lower than those elicited from respondents who did not have cancer: 0.65 versus 0.73 for chronic phase CML; 0.72 versus 0.81 for hematologic response; 0.83 versus 0.89 for cytogenetic response; and 0.89 versus 0.95 for molecular response. CONCLUSIONS: The health states with poorer outcome (e.g., hematologic response) were associated with a lower preference value than the state with the best outcome (i.e., molecular response). The data demonstrate the impact that different treatment responses may have on the health-related quality of life of patients with chronic phase CML and can be used to estimate the outcomes of interventions in terms of quality-adjusted life-years.

**PCN119**

**COMPARISON OF EQ-SD SCORE BETWEEN TREATMENT WITH 4 CYCLES OF ANCITHRACYCINE FOLLOWED BY 4 CYCLES OF TAxANe AND 8 CYCLES OF TAXANe FOR NOde POsITIVE BREAST CANCER PATIENTS AFTER SURGERY: N-SAS BC 02 TRIAL**

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OBJECTIVES: We investigated the effect of adjuvant chemotherapy regimens on utility scores assessed by the EQ-SD instrument in a randomized controlled trial for breast cancer patients after surgery. METHODS: In the National Surgical Adjuvant Study of Breast Cancer-02 (N-SAS BC 02), 1060 patients were randomly assigned to the following four chemotherapy groups: 1) four cycles of anthracycline (ADM 60 mg/m2+ EP 60 mg/m2); 2) four cycles of anthracycline followed by docetaxel (75 mg/m2 q3wks x 4) (ACP); 3) eight cycles of paclitaxel (175 mg/m2 q3wks x 8) (ACD); and 4) four cycles of anthracycline followed by docetaxel (75 mg/m2 q3wks x 4) (ACD); 3) eight cycles of paclitaxel (175 mg/m2 q3wks x 8) (PTX); and 4) eight cycles of docetaxel (75 mg/m2 q3wks x 8); The first consecutively registered 300 women were the subjects of the present utility study. Utility scores were assessed using the EQ-SD instrument at baseline, 3rd cycle, 5th cycle, 7th cycle, 7 months, and 1 year. The obtained data were analyzed using a linear mixed model with baseline, time, group, and interaction between time and group as explanatory variables. RESULTS: Missing data was observed between 1.9 and 6.1% of cases depending on the time of measurement. The utility score was significantly lower in the DTX baseline in nonresponse and disease progression states. AEs had an important impact on utility within the PFS response state. The severe infection AE appeared to have a greater impact on patients’ lives than the other AEs. This study sought to confirm the adequacy of a 25 cutpoint on the EQ-SD “worst pain” item for assessing pain progression in CRPC patients using data collected during a multi- directional phase III clinical trial. METHODS: Patients with a BPSF worst pain score ≥ 25 were compared with patients with a score < 25 in terms of Functional Assessment of Cancer Therapy—Prostate (FACT-P) subscales and total score and EQ-SD item scores. Exploratory analyses were also conducted to investigate any potential differences within designated regional subgroups of patients. All analyses were performed using treatment-blinded data collected at the first post-baseline trial visit including the above assessments (Week 12). RESULTS: A total of 464 patients completed the BPSF at Week 12 (≥ 25 n = 411), ≥ 5 n = 53). Mean FACT-P total scores for patients with a BPSF worst pain score ≥ 25 were 24.5 points lower than for patients with a score < 25 (9.1 vs. 11.5, P < 0.001), indicating poorer well-being. Patients with BPSF worst pain scores ≥ 25 consistently had lower scores for all FACT-P subscales (P < 0.001) except for social well-being. The magnitude of these differences, for all scales, were considerably greater than reported thresholds for meaningful difference. Results for EQ-SD item scores were in a similar direction with significantly greater impairment reported in patients with a BPSF worst pain score ≥ 25 compared with patients with a score < 25 (P < 0.001). Exploratory analyses also revealed similar results across all regional subgroups of patients. CONCLUSIONS: Patient scores ≥ 25 on the BPSF “worst pain” item are associated with significant and meaningful impairments in CRPC patients, thus supporting the adequacy of this cutpoint as an appropriate definition of pain progression in this population.

**PCN120**

**UTILITY AND WORK PRODUCTIVITY DATA FOR ECONOMIC EVALUATION OF BREAST CANCER THERAPIES IN THE NETHERLANDS AND SWEDEN**

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OBJECTIVES: Survival and quality of life (utility) are often the main measure of benefit used in an economic evaluation. Additionally, some decision-makers will consider benefits in terms of work productivity. The present study was designed to estimate utilities and productivity loss for women with metastatic breast cancer (MBC) which is Human Epidermal Growth Factor Receptor 2 positive (HER 2+). METHODS: Health-state vignettes describing MBC progressive disease, stable disease, and seven grade 3/4 adverse events (diarrhea, fatigue, anemia, leukopenia, anorexia, decreases in left ventricular ejection fraction [LVEF], and skin rash) were developed based on interviews with women with MBC in the Netherlands and Sweden. In a general population survey many years ago a graded general public rated the states (100 men and women in NL; 100 women aged 50+ in Sweden) using the time trade off method. Women (161 The Netherlands, 52 Sweden) who were currently or recently treated for MBC were surveyed using the Work Productivity and Activity Impairment scale regarding the impact of disease on their ability to work. RESULTS: MBC progressive disease and stable disease were rated more highly in Sweden (0.61, 0.81) than the The Netherlands (0.50, 0.69). Utilities for toxicities ranged from 0.52 to 0.69 (Sweden), and 0.47 to 0.66 (NL). The productivity survey identified that women currently receiving treatment reported that their overall productivity was reduced by 69% (NL) and 72% (Sweden); while those who had recently completed therapy reported reductions of 41% (NL) and 40% (Sweden). CONCLUSIONS: This study captured utility and productivity data for the Netherlands and Sweden regarding the impact of HER 2+ MBC. Important differences in utilities emerged in the study which could impact cost-effectiveness estimates. The productivity survey demonstrated how the negative impact of breast cancer on productivity persists after women have completed their treatment.