View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by Elsevier - Publisher Connector

PCN28

ECONOMIC EVALUATION OF SWITCHING TO EXEMESTANE AT 2–3 YEARS VERSUS CONTINUING TAMOXIFEN AS ADJUVANT THERAPY IN EARLY BREAST CANCER: A FINNISH PERSPECTIVE

Färkkilä N[1], Kotomäki T[2], Jormanainen V[2]
[1]Karolinska Institutet, Stockholm, Sweden, [2]Pfizer Oy, Helsinki, Finland

OBJECTIVES: The study objective was to estimate cost effectiveness of exemestane adjuvant treatment compared to tamoxifen for early-stage oestrogen-receptor-positive breast cancer after 2–3 years treatment with tamoxifen in postmenopausal women in Finland. **METHODS:** The analyses are based on the Intergroup Exemestane Study (IES) results. According to the IES exemestane improved disease-free survival, and decreased risk of distant recurrence and contralateral breast cancer. A Markov model was used to calculate costs and health outcomes over patients' lifetime period. The Finnish model adaptation was carried out by populating the model with country-specific current care practices, costs and mortality statistics. The costs were included from societal perspective. The health state utilities used in the model were taken from a range of international studies. Health outcomes were assessed in terms of life years, QALYs and disease-free life years gained. Probabilistic sensitivity analysis, with 1000 repeated simulations, was performed to test robustness of the model parameters and assumptions. **RESULTS:** The base case analysis resulted in incremental 16,185 EUR/QALY gained with exemestane versus tamoxifen. The incremental cost per life year gained was 15,456 EUR whereas it was 11,858 EUR per disease-free life year gained. Based on the probabilistic sensitivity analysis there is a 67% chance that exemestane is cost-effective alternative to tamoxifen at a value of 20,000 EUR/QALY gained, increasing to 90 percent if the decision maker is willing to pay 30,000 EUR. **CONCLUSION:** The strategy of switching early-stage postmenopausal breast cancer patients to exemestane following two-to-three years of treatment with tamoxifen is a cost effective alternative compared to standard tamoxifen therapy taken for five years in Finland.

PCN29

COST-EFFECTIVENESS OF MAINTENANCE RITUXIMAB TREATMENT AFTER SECOND LINE THERAPY IN PATIENTS WITH FOLLICULAR NON-HODGKIN'S LYMPHOMA IN SWEDEN

Kasteng F[1], Erlanson M[2], Hagberg H[3], Kimby E[4], Relander T[5], Lundkvist J[1]
[1]i3 Innovus, Stockholm, Sweden, [2]Umeå University Hospital, Umeå, Sweden, [3]Uppsala University Hospital, Uppsala, Sweden, [4]Karolinska University Hospital, Stockholm, Sweden, [5]Lund University Hospital, Lund, Sweden

OBJECTIVES: This economic evaluation assesses the cost-effectiveness of rituximab added as maintenance therapy once every three months for two years after induction chemotherapy for patients with relapsed/refractory follicular lymphoma in Sweden, primarily based on data from the EORTC20981 trial. **METHODS:** The economic model evaluates the incremental cost and effectiveness of rituximab maintenance therapy versus observation alone. A hypothetic patient cohort, aged 55 years at the start of simulation, was followed in a state-transition Markov model in monthly cycles over a period of 30 years. Primary clinical endpoints were quality-adjusted life-years (QALYs) and life-years gained (LYG). Progression-free and overall survival data from the EORTC20981 trial were used to calculate model state transitions. The analysis was made from the perspective of the health care provider, including direct medical costs presented in €2006 value. Effects and costs were discounted at a 3% annual rate. One-way sensitivity analyses were performed to test the stability of the results and identify input parameters with particular influence on the results. A probabilistic sensitivity analysis was performed to test the joint instability of the model parameters. **RESULTS:** The calculations showed that rituximab maintenance therapy was associated with an incremental cost per QALY gained of €12,600 and an incremental cost per LYG of €11,200. The average discounted life expectancy in the rituximab group was 1.0 years longer than with observation (5.96 versus 4.94). Rituximab maintenance was associated with an additional 0.89 QALYs and total costs per patient were €11,500 higher in the treatment arm, compared to observation. The cost difference was mainly attributable to cost and administration of the study drug. Sensitivity analyses showed that the results were stable. **CONCLUSION:** The results indicate that maintenance treatment with rituximab after induction therapy for patients with relapsed/refractory follicular lymphoma in Sweden is cost-effective as compared to observation alone.

PCN30

THE ECONOMIC BENEFITS OF TEGAFUR WITH URACIL (UFTORAL) IN FIRST- LINE METASTATIC COLORECTAL CANCER

Ralston SJ, Almond J
Merck Serono, Feltham, Middlesex, UK

OBJECTIVES: Tegafur with uracil (Uftoral) is one of two oral fluoropyrimidine therapies approved by NICE for the first-line treatment of metastatic colorectal cancer. The other therapy is a 5-fluorouracil pro-drug, capecitabine. The purpose of this study was to compare the cost-effectiveness of tegafur with uracil (when prescribed with folinic acid) against capecitabine and other standard intravenous 5-fluorouracil regimens. **METHODS:** A literature review was conducted to assess the relative clinical effectiveness of the different therapies under assessment. A similar assessment was completed by Ward et al. Costs were calculated from the UK NHS perspective for the full cost of treatment included drug acquisition, drug administration, and the treatment of adverse events. A cost minimisation analysis was utilised. Direct randomised controlled trial comparisons of the oral therapies with infusional 5-fluorouracil schedules were not available, though this assumes that all treatments are of equal efficacy. **RESULTS:** The cost-minimisation analysis showed that treatment costs for a 12-week course of capecitabine (≤2132) and tegafur with uracil (≤1788) were lower than costs for the intravenous Mayo regimen (≤3593) and infusional regimens on the de Gramont (≤6255) and Modified de Gramont (≤3485) schedules over the same treatment period. For tegafur with uracil, this represents a cost saving of ≤343 versus capecitabine and ≤1696 versus the modified de Gramont. **CONCLUSION:** The two oral therapies approved by NICE both result in lower costs to the NHS than intravenous therapies. Tegafur with uracil represents cost savings both per patient, but significant cost savings can be accrued when extrapolated over the whole potential patient population. Differences in this study are primarily driven by drug acquisition cost. This study does not take into account hand and foot syndrome which is a prominent side effect in all treatments except tegafur with uracil and results in resource utilisation and nurse time.