Abstracts

be broken up into three components: costs associated to the preparation time (71%), material costs (27%), and the waste management costs (2%). For 100 patients treated receiving 10 cycles of chemotherapy, this represents a total saving of €1040. CONCLUSIONS: Using oxaliplatin concentrated solution form represented a time saving and an economic benefit for the hospital pharmacist. In addition, this new solution form increases the safety aspects by reducing risk of preparation errors and risk of cytotoxic drug exposure for manipulators. It would be interesting to confirm those results in a multi-centric analysis.

ECONOMIC EVALUATION OF FOLFOX4 VERSUS FOLFOX7 WITH OXALIPLATIN STOP-AND-GO IN ADVANCED COLORECTAL CANCER PATIENTS

Tilleul P1, Jasso Mosqueda G2, Transart A2, Joly AC1, Tournigand C1, Maindruart-Goebel F1, Le Pen C2, De Grammont A1
1Saint-Antoine Hospital, Paris, France. 2Aremis-aegienet, Neully sur Seine, France

OBJECTIVES: OPTIMOX1 randomised study demonstrated that FOLFOX7 with oxaliplatin stop-and-go could be safely used and achieved the same efficacy results as standard treatment FOLFOX 4 in advanced colorectal cancer. The median progression free-survival and survival times were 9.0 and 19.3 months, respectively in FOLFOX4 arm compared with 8.7 and 21.2 months, respectively in FOLFOX7 arm (p = non significant). FOLFOX 7 stop and go strategy was associated with reduced risk of grade 3 to 4 toxicity [Tournigand, JCO 2006;24:354]. The main objective was to perform an economic evaluation of FOLFOX7 stop-and-go compared with FOLFOX4 regimen in advanced colorectal cancer. METHODS: A cost-minimisation analysis has been conducted based on the efficacy results of OPTIMOX1 study. The perspective was that of the third party payer and included only direct medical costs: chemotherapy, hospitalisation and side effects management. The horizon time was from inclusion until patient death. Sensitivity analyses were performed on drug costs and full/day hospitalisation rates. RESULTS: Hospitalisation costs per patient were the main driver for cost. Hospitalisation represented €6595 in FOLFOX7 arm vs. €10,522 in FOLFOX4 arm reflecting the decrease of number of hospitalisation days (p < 0.001). Chemotherapy costs per patient were comparable in each treatment arm despite higher doses of oxaliplatin with FOLFOX7 (€6870) compared to FOLFOX4 (€7047) (p = 0.30). The cost of side effects management appeared very low in both groups, compared to hospitalisation and drug costs with €271 and €382 (p = 0.11) for FOLFOX4 and FOLFOX7 respectively. The mean total cost per patient was higher in FOLFOX4 arm than in FOLFOX7 arm with 17,841 versus €13,847 respectively (p < 0.001). CONCLUSION: The FOLFOX7 regimen with intermittent oxaliplatin treatment (stop-and-go) is cost saving compared with FOLFOX4 regimen.

A COST MINIMISATION ANALYSIS OF NAVELBINE-CISPLATIN VERSUS GEMCITABINE-CISPLATIN IN ADVANCED NON-SMALL CELL LUNG CANCER IN POLAND

Skowron A1, Polak S, Brandsy J
Jagiellonian University, Cracow, Malopolska, Poland

OBJECTIVES: To compare costs of nabovelbine-cisplatin (PN) versus gemcitabine-cisplatin (PG) recommended in non small cell lung cancer (NSCLC) treatment in Poland. METHODS: Data of health outcome, adverse event rates, specification for each regimen and the number of cycles derived from the published head-to-head clinical trial (Martoni & co. European Journal of Cancer 41, s.81–92, 2005). Only direct medical cost were assessed such as diagnostic tests, cytostatics and additional medication used and hospitalization (cost of blood tests and antiemetics included). The payer’s perspective were chosen. Information of value of health resources consumed were derived from the medical valuation system used by National Fund of Health in 2006. All cost were in polish zloty (in 2006: 1 euro = 3,95 zloty). RESULTS: Because there were no statistically significant differences in effectiveness between analyzed regimens, the cost-minimisation analysis were performed. The average total costs per patient was 10,452 zl for PN and 31,478 zl for PG. However in both regimens the main part of total costs were cost of gemcytabine (60%) or navelbine (55%), the nominal value amount 3668 zl for navelbine and 18,860 zl for gemcytabine. In PG scheme 7% were cost of hospitalization and 4.5% cost of ADR treatment. In PN scheme 21.5% were cost of hospitalization and 15.4% cost of ADR treatment. The high cost of ADR management for PN were caused by cost of neutropenia treatment. CONCLUSIONS: Despite of high percentage of ADR management in PN, our analysis showed that total cost of chemotherapy with this scheme is three times less than chemotherapy with PG. So the PN regimen should be recommended as cost saving for patients with advanced NSCLC, specially as a palliative chemotherapy.

COST-MINIMIZATION ANALYSIS OF ORAL VS. IV FLUDARABINE FOR THE TREATMENT OF B-CELL CHRONIC LYMPHOCYTIC LEUKEMIA (B-CLL) IN BRAZIL

Araujo G1, Fonseca M1, Bigni R2
1Axia, Bio Consulting, São Paulo, Brazil, 2INCA, Rio de Janeiro, Brazil

OBJECTIVES: The oral formulation of fludarabine phosphate is equivalent to the IV formulation in terms of clinical efficacy, in previously untreated B-CLL. The objective of this evaluation is to perform a cost minimization analysis. METHODS: To conduct this evaluation the following parameters were considered: acquisition value of the IV and oral fludarabine by the public health system (PHS); resources consumption for IV fludarabine application; toxicity profile of the two presentations based on literature data; adverse events management and their resource consumption according to the Inca; PHS reimbursement for the patients hospitalized with LCC; an index patient with 1.69 m² body surface area and 60 years old; oral and IV fludarabine dose of 40 mg/m² and 25 mg/m² respectively. The treatment cost of a given adverse event was considered to be the same irrespective to the fludarabine presentation. RESULTS: Although oral fludarabine presented a lower cost per mg in comparison to the IV formulation (R$9.85 vs. R$10.20) the total drug cost for the whole treatment is greater for the oral formulation than for IV (R$20,676.60 vs. R$15,300.00). However considering that the administration cost per cycle of the IV formulation is R$956.80 the overall cost of IV fludarabine becomes higher than the oral formulation (R$22,150.78 vs. R$23,160.31). The cost of the treatment of each considered adverse event for oral and IV fludarabine were respectively: infection (339.72 vs. 519.99); neutropenia (962.79 vs. 1187.75); anemia (106.02 vs. 222.74); diarrhea (11.97 vs. 0.00); nausea (2.25 vs. 7.11) and thrombocytopenia (52.47 vs. 182.05). Overall IV fludarabine costs 4.56% more than its oral formulation. CONCLUSIONS: This preliminary analysis shows that oral fludarabine has lower total cost per patient with similar efficacy to IV fludarabine with lower adverse events and administration costs. A cost effectiveness analysis should confirm these promising data.