one participating centre. Costs were evaluated for the first hospitalization period post-transplant (FP) and for the total duration of the follow-up period (OP). All prices are expressed in FRF 2000 currency. Due to the small sample size non-parametric rank testing was used to determine whether significant differences existed (p < .05, two sided).

RESULTS: Average FP cost per patient was 245,603.4 FRF (SD: 92,950.1) for C and 218,131.8 FRF for FI (SD: 61,711.7). Cost difference was 27,352.9 FRF (11%) in favor of the filgrastim arm (p = .15). Average OP cost per patient was 267,784.9 FRF for C and 244,974.6 FRF for FI. The cost difference did not change during follow-up. Main cost drivers were, as expected, the cost of hospitalization and of IV antibiotic drugs. On average, FI patients leave the ICU 2.8 days earlier than P patients during FP. CONCLUSION: Use of filgrastim 24 hours post-PBPC following high dose chemotherapy for n-HFL patients could result in important cost reductions, mainly attributable to a shorter hospitalization in ICU and a lower use of IV-antibiotics.

PCN8

COST OF MANAGING SEVERE HYPERURICEMIA AND TUMOUR LYSIS SYNDROME IN HAEMATOLOGIC MALIGNANCIES
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OBJECTIVES: Hyperuricemia (HU) and tumour lysis syndrome (TLS) are important complications leading to increased morbidity and mortality in patients with acute lymphoid or myeloid leukaemia (ALL/AML) and non-Hodgkin lymphoma (NHL). The objective was to calculate incidence and average cost of managing HU and TLS in current daily practice from the payer’s perspective.

METHODS: Seven hundred eighty eight patients, both adults and children, from Belgium, Holland, Spain and the UK, who received induction treatment between 1999 and 2000, were screened retrospectively for the occurrence of HU or TLS. In patients fulfilling predefined diagnostic criteria, HU or TLS-related resource use was recorded and costs calculated by applying local unit costs.

RESULTS: HU was detected in 18.9% of screened patients, TLS in 5.0% despite 79% prophylaxis. The average cost of HU in the absence of TLS was 672 Euro (SE = 181), of which 218 Euro were for medication and 376 Euro for the hospital stay. The average cost of TLS was 7,342 Euro (SE = 1,412) of which 5,837 Euro was related to additional hospitalization, 719 to interventions (mainly dialysis) and 446 Euro to medication. TLS patients requiring dialysis incurred an average cost of 17,706 Euro compared to 3,887 in non-dialysed TLS cases. Inter-country differences in costs were observed and were solely due to differences in unit costs. Age or underlying malignancy had no significant impact on management costs.

CONCLUSIONS: Rates of HU and TLS observed were at the low end of the range compared to previously published reports in specific indications. There is a large variation in costs, and distributions are highly skewed. Patients developing TLS incur 11 times greater costs than patients with HU in whom development of TLS can be prevented. The main cost driver in TLS patients is the need for interventions (dialysis and haemofiltration) that require ICU admission and extra hospital stay.

PCN9

COST-EFFECTIVENESS OF IMAGE-GUIDED VERSUS BLIND INSERTION OF HICKMAN LINES IN ADULT CANCER PATIENTS BY NURSES
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OBJECTIVE: In the United Kingdom NHS, approximately 200,000 central venous catheters are inserted in adult patients per year. The most frequently inserted central venous catheter is the Hickman line. As the mean cost of a Hickman line insertion is estimated to be £450, the annual cost to the NHS is substantial.

METHODS: A prospective randomised controlled trial was conducted at the Christie NHS Trust (UK) to compare blind versus image-guided approaches to Hickman line insertions. Blind insertions were performed at the patient’s bedside whilst image-guided insertions were performed in the interventional x-ray suite. An incremental cost-effectiveness analysis was carried out alongside the clinical trial from the perspective of the NHS. Main clinical outcome measures included pneumothorax, arterial puncture and catheter tip misplacement. The primary economic outcome of interest was the incremental cost per misplaced catheter tip avoided.

RESULTS: There were no clinically or statistically significant differences in pneumothorax or arterial puncture rates across the blind arm (n = 235) and the image-guided arm (n = 235) of the trial. Catheter tip misplacement occurred in 1% of image-guided insertions and in 14% of blind insertions. However, patient and professional perception of catheter tip misplacement appeared to demonstrate that the difference was statistically significant rather than clinically significant. Economic evaluation results concluded that the total cost of image-guided insertion of Hickman lines (£110,000) was similar to that of blind Hickman-line insertions (£104,000).

CONCLUSIONS: The study shows that the vast majority of Hickman-line insertions can be successfully inserted blind at the bedside by nurses. Nevertheless, image-guided insertions may lead to greater clinical benefits for some groups of patients. Economic evaluation results demonstrate that image-guided insertions are more cost-effective than blind insertions. However, cost-effectiveness of the image-guided approach is limited by the availability of the interventional x-ray suite.