for the product A and 40% for the product B and were asked for their willingness to pay for product A.

Results: At this time, 31 patients had been enrolled: men: 20 (64,5%), age: 64,5 ± 11,7 years, hairless: 4 (13%). In analogical visual scale, the impact of alopecia were assessed at 4,7 ± 3,5, median: 5. The mean amount patients were willing to pay by 3-week chemotherapy cycle is 83,3 ± 141,7 euros (median 12,5 euros); 12 (38,7%) of the patients are not ready to pay for the product A.

Discussion and Conclusion: complete results and analysis in relation with the willingness to pay stratified by sex, age, employment and income will be presented at the meeting.

P1-245 **Supportive Care/QOL Posters, Mon, Sept 3**

Economic impact of second- and third-line erlotinib treatment of non small-cell lung cancer: a French observational study

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Background: There are few data on the economic consequences of targeted cancer therapies.

Objective: This study examined care consumption and management costs among patients who received second- or third-line oral erlotinib therapy for non small-cell lung cancer (NSCLC).

Methods: The study involved two observational cohorts of NSCLC second- or third-line treated patients. In the first, created in 2005 (before erlotinib became available), the patients received IV chemotherapy alone (IV cohort, 233 patients), while the patients in the second cohort, created in 2006, received oral erlotinib (oral cohort, 166 patients). Only direct costs were taken into account (drug acquisition and administration, hospitalization, consultation, costs of managing common toxicities). The analysis adopted the payer's perspective.

Results: Treatment lasted a similar length in the IV and oral cohorts during second-line treatment (94.5 ± 67.5 and 105 ± 79.4 days, p = 0.07) but was significantly longer in the oral cohort during third-line therapy line (76.6 ± 96.5 versus and 114.4 ± 74.5 days, p < 0.008). There were more women in the oral cohort (41% versus 26.2%, p=0.023) and a higher rate of adenocarcinoma (60.8% versus 47.2%, p = 0.0043). There was no difference in smoking status or the disease stage at diagnosis. Likewise, the rate of conventional hospitalization was not different between the two cohorts. In contrast, during 100 days of management, the patients in the oral cohort tended to spend less time in hospital during second-line treatment (3 ± 6.6 vs 7.7 ± 18.3 days, p = 0,057), and the difference was statistically significant during third-line treatment (4.8 ± 11.7 vs 8.7 ± 14 days, p<0.05). Regardless of the line of treatment, the oral cohort made significantly fewer stays in daycare clinics (p<0.001), and received significantly less antiemetic treatment (p<0.0001), erythropoietin (p<0.005) and G-CSF (p< 0001). In contrast, these patients required more treatment for skin rash (p<0.001).

Monthly management costs per patient in the IV and oral cohorts were respectively 3126 and 2750 euros during second-line treatment and 3026 and 2823 euros during third-line treatment (no significant difference). A sensitivity analysis showed that the results in the IV cohort were dependent on the cost of chemotherapy.

Discussion: One limit of this study is that transport costs were not taken into account. Conclusion: In oral cohort, the cost of Erlotinib is compensated by the reduction of daycare hospitalization costs and the limited cost of medication to treat adverse events compared to IV chemotherapy such as erythropoietin or G-CSF.

Conclusion: These results must be validated by prospective observational studies focusing on quality of life and the time spent in hospital.

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P1-246 **Supportive Care/QOL Posters, Mon, Sept 3**

Risk model for neutropenic complications in lung cancer patients receiving cancer chemotherapy

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Risk model for neutropenic complications in lung cancer patients receiving cancer chemotherapy. J. Crawford, D.C. Dale, N.M. Kuderer, D.A. Wolff, E. Culakova, M.S. Poniewierski, G.H. Lyman for the ANC Study Group; Duke University Medical Center, Durham, NC; University of Washington School of Medicine, Seattle, WA, University of Rochester School of Medicine/Dentistry, Rochester, NY, USA

Introduction: A prospective cohort study was undertaken to develop risk models for neutropenic complications (NC) consisting of severe or febrile neutropenia (FN) among cancer patients receiving chemotherapy. Models are presented of the risk of such events among lung cancer patients initiating a new chemotherapy regimen.

Methods: Of 907 lung cancer patients, data on 1 or more cycles of chemotherapy were available on 863 lung cancer patients (665 non small cell lung cancer [NSCLC] and 198 small cell lung cancer [SCLC]) initiating a new chemotherapy regimen at 115 randomly selected U.S. oncology practice sites. Univariate and multivariate proportional hazards regression analyses were undertaken to assess the time from treatment initiation to the initial NC up to 4 cycles of chemotherapy. In the absence of events, patients were censored at the last time seen.

Results: Of the 863 patients with data on at least 1 cycle of chemotherapy, NC (or FN) was experienced over a median of 3 cycles in 15% (5%) with NSCLC and over a median of 4 cycles in 40% (18%) with SCLC. Four evaluable cycles of treatment were completed in 45% and 58% of patients with NSCLC and SCLC, respectively. Independent clinical risk factors for NC in patients with NSCLC include: leukopenia (hazard ratio [HR]=2.1); hyperglycemia (HR=1.8); elevated bilirubin (HR=2.6) and alkaline phosphatase (HR=1.7); recent surgery (HR=1.8) or chemotherapy (HR=2.9); regimens incoporating cisplatin or carboplatin (HR=4.9), docetaxel (HR=2.2), gemcitabine (HR=2.8), or vinorelbine (HR=5.1); planned relative dose intensity >85% (HR=1.8) while prophylactic myeloid growth factor was associated with a significant decrease in risk (HR=0.40). Alternatively, significant independent risk factors for NC among patients with SCLC include: elevated bilirubin (HR=3.9); concurrent immunosuppressives (HR=2.0); regimen based on topoisomerase inhibitors (HR=5.1) and age >65 years (HR=1.9) and thrombocytopenia (HR=3.4) while reduced risk was observed with growth factor prophylaxis (HR=0.41). Model fit for both models was excellent by a likelihood ratio test (P<.0001).

Conclusions: Multivariate analysis for NC identifies overlapping as well as distinct risk factors for patients with NSCLC and SCLC receiv-

ing systemic chemotherapy. Such risk models may have applicability in identifying patients at increased risk for early NC. Independent validation of these models will be conducted in a separate population of lung cancer patients.

P1-247 **Supportive Care/QOL Posters, Mon, Sept 3**

MESOTHELIOMA UK - Developing a national resource centre for mesothelioma

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In 2002 a proposal was made to Macmillan Cancer Relief (now known as Macmillan Cancer Support) to support the establishment of Mesothelioma UK, the National Macmillan Mesothelioma Resource Centre at Glenfield Hospital, Leicester. The Centre opened in 2004.

Methods:

The objectives of the centre are:

- To provide high quality, impartial and up-to-date information to all UK mesothelioma patients, their carers, health care professionals and associated organisations.
- To provide regional support for ongoing development in the mesothelioma field through the continued development of a national network of trained and experienced nurse specialists.
- To establish a consultant nurse post to provide overall leadership to the work of Mesothelioma UK, including nurse-led research.
- To work in collaboration with individuals interested in mesothelioma and with interest related groups.
- To explore the feasibility of establishing and developing a network of mesothelioma support groups.
- To promote the problems and issues raised by mesothelioma through mediums such as articles, conferences and the media.

Results: From the current progress already achieved by the Macmillan Mesothelioma UK Project, it can be anticipated that all its objectives will be achieved by the end of the three years. The value of services provided by Mesothelioma UK on a national level, to the public and to health care, can already be demonstrated and is expected to grow.

Conclusion: This presentation will chart the development of Mesothelioma UK and highlight the achievements and benefits of establishing a co-ordinated approach to provide support and information for a rare tumour such as mesothelioma.

P1-248 **Supportive Care/QOL Posters, Mon, Sept 3**

Lung cancer guideline development in ontario: impact on policy and practice

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Background: The multidisciplinary provincial Lung Disease Site Group (LDSG) has met regularly for the past 10 years to develop practice guidelines (PGs). Current members include medical (17) and radiation (11) oncologists, thoracic surgeons (4) and research coordinators (1). A medical sociologist, patients, pathologists, and nurses have participated in specific PG development activities.

Methods: The LDSG has used the practice guideline (PG) development cycle described by Browman GP et al (JCO 1998; 16(3):1226-31).

Results: 31 reports, including 25 PGs have been published in peer-reviewed journals and all PG's are posted on CCO's website, www.cancercare.on.ca. Initial guideline topics were selected on the basis of known practice variation, controversy in practice, or new and emerging data with potential to change practice. PGs for single chemotherapy drugs (6) or chemotherapy usage for specific situations (7) have dominated DSG activity and have commonly informed the provincial funding decisions that make new and expensive drugs available for specific indications.

5 PGs on radiotherapy alone and 3 on RT as part of combined modality therapy (CMT) have been completed. An analysis of fractions used for curative radiotherapy in stage III NSCLC by treatment centre suggests wide adoption although low numbers of treated patients per Centre implies that appropriate patients are either not being referred or co-morbidities in this patient population preclude the routine application of PG recommendation.

A review of evidence on Positron Emission Tomography (PET) in lung cancer supported its use in the assessment of solitary pulmonary nodules when other diagnostic tests failed, but provided conflicting evidence in relation to its role in the clinical management of early stage, potentially resectable (Stage I-IIIa) and locally advanced, inoperable NSCLC. As a consequence, two clinical trials have been initiated to evaluate the clinical utility of PET in managing patients with NSCLC.

Conclusion: LDSG PGs have informed Ontario government funding decisions for chemotherapy drugs, influenced radiation therapy practice in Ontario cancer treatment centres and resulted in evaluative studies of PET technology. As well, through an updating process, they remain an excellent reference on current best practice that can be used by trainees and practitioners globally.

P1-249 **Supportive Care/QOL Posters, Mon, Sept 3**

Anemia rates in completely resected non-small cell lung cancer (NSCLC) patients receiving adjuvant chemotherapy; An interim analysis

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Background: Recent data from both the National Cancer Institute of Canada (NCIC) and other studies has shown that early stage NSCLC patients receiving adjuvant chemotherapy after complete resection may have a significant survival advantage as compared to surgery alone. The NCIC JBR10 study showed that 91% of patients receiving platinum-based adjuvant chemotherapy experienced anemia, with 38% being grade 2 or higher. It is well known that platinum-based chemotherapy causes anemia. Subsequent exploratory analyses to this study documenting the rate of anemia in the adjuvant NSCLC patient population and assessing impact on outcomes demonstrated that lower baseline