QALY) for etanercept compared with NST. Patients considered had chronic plaque psoriasis, PASI of 10–12 and any DLQI value at baseline. Response rates were taken from a pooled analysis of three studies of etanercept. Utility gain associated with response was assessed using patient level DLQI change mapped to EQ5D. Clinical and quality of life outcomes were extrapolated to a time horizon of ten years. Costs were estimated from a UK payer perspective including drug cost, administration visits and hospital stay for treatment failures. Probabilistic sensitivity analysis was undertaken. RESULTS: The model estimated incremental cost per QALY gained compared with NST to be: £2,850 (95% CI: Dominant to £6,084) for etanercept 25 mg biw and £10,351 (£7,056, £15,911) for etanercept 50 mg biw. Cost-effectiveness was sensitive to the duration of treatment holiday and response rate after therapy interruption. Cost per QALY gained in patients with baseline PASI in the range 10–72 and poor quality of life at baseline has previously been reported to be £3,299 for etanercept 25 mg biw and £10,923 for etanercept 50 mg biw. CONCLUSIONS: The model found treatment of a less severe psoriasis population to be cost-effective. Cost-effectiveness was comparable to findings in patients with more severe disease and poor quality of life at baseline.

PSY12

COST-EFFECTIVENESS OF FOOD FOR SPECIAL MEDICAL PURPOSES RELATIVE TO STANDARD CARE IN PATIENTS UNDERGOING ABDOMINAL SURGERY

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OBJECTIVES: To assess the cost-effectiveness of Food for Special Medical Purposes (FSMP) for the prevention of malnutrition in patients undergoing abdominal surgery from the perspective of the society in The Netherlands. METHODS: The costs and benefits of the two treatment strategies were assessed using a linear decision analytic model reflecting treatment patterns and outcomes in abdominal surgery. The model structure allowed for differences in costs and length of stay. The incremental cost difference was based on costs associated with cost of FSMP and hospitalization. Clinical probabilities and resource utilization were based on clinical trials and published literature; cost data were from official price tariffs. RESULTS: The use of FSMP reduces the costs from €3318 to €3066, which corresponds with a €252 (7.6%) cost savings per patient. The additional costs of FSMP are more than balanced by a reduction on hospitalization costs. The hospitalization costs reduce from €3318 to €3044 per patient, which is a 8.3% cost saving and corresponds with 0.72 days reduction in LOS. The use of FSMP would lead to an annual cost saving of €40.4 million based on the number of 160,283 abdominal procedures per year in The Netherlands. Sensitivity analyses were performed on all parameters, including length of stay and per diem costs. The results showed that the use of FSMP in all sensitivity analyses remain cost saving compared to “no use” of FSMP. A threshold analysis on the length of stay shows that at length of stay of 0.64 days, the use of FSMP is still cost-effective. CONCLUSIONS: The use of FSMP is a very cost-effective treatment in The Netherlands and is dominant over standard care without FSMP: cost savings and higher effectiveness.

PSY13

WITHDRAWN

PSY14

COST-EFFECTIVENESS (CE) EVALUATION OF THE USE OF RITUXIMAB-CHOP VS. CHOP SCHEMES FOR THE TREATMENT OF AGGRESSIVE NON-HODGKIN LYMPHOMA (NHL) STAGES III AND IV: TREATMENT IMPACT OVER RELAPSE AND SURVIVAL, AT THE MEXICAN-NATIONAL CANCER INSTITUTE (MEX-INCAN)

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OBJECTIVES: To perform a CE evaluation of the use of CHOP vs R-CHOP for the treatment of aggressive NHL stages III and IV. METHODS: After a review of the medical literature about the economic impact of NHL treatment, we performed an analysis of the resources consumed by 116 patients with the diagnostic of NHL during 2004 in the Mex-InCan. The economic evaluation was done using an hypothetical cohort simulation through a five years by means of Markov Model with monthly transitions, using a five percent discount rate. The model included 11 health status: Diagnostic; 1st-line treatment, 1st-remission, 1st-relapse, 1st-progression, 2nd-line treatment