ence measures and utility values for individual treatment attributes. Differential toxicity attributes, that were patient relevant and clinically significant, were identified from head-to-head trial data. Attributes identified were: alopecia, weight loss, mucositis, diarrhoea, and febrile neutropenia/neutropenic sepsis. Fourteen oncologists and 16 oncology nurses served as patient proxies given the sensitive nature and ethical difficulties associated with the patient population. Respondents considered an orthogonally designed series of pair-wise choice scenarios representing incidence levels for individual toxicity attributes (treatment features) with trade-offs in life-expectancy. A logistic regression was utilised to analyse the stated scenario pair preferences against the individual attribute levels. Potential confounders were analysed. RESULTS: Survey results indicate a strong preference for GC treatment and a clear willingness-to-trade-time for tolerability benefits. Analysis of strength of preference for individual attributes shows strong support for treatment features that impact directly on QoL. CONCLUSIONS: UK respondents displayed a clear preference for GC treatment with superior toxicity offering a highly valued health related QoL gain. These results provide encouragement for further exploration, possibly by extension to the European setting. Discrete choice conjoint analysis is a promising instrument in the outcomes assessment of cancer therapies.

CANCER—Clinical Outcomes

IS THERE DIFFERENCE BETWEEN GEMCITABINE BASED NSCLC TREATMENT AND OTHER PLATINUM BASED COMBINATIONS FOR RESPONSE RATES AND TOXICITY?

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OBJECTIVE: This analysis attempts to highlight the differences in response rates and toxicity between Gemcitabine combined with a platinum-based therapy and other combinations of platinum-based chemotherapy, in the treatment of non-small-cell lung cancer (NSCLC). METHODS: This pooled analysis used summary statistics from clinical trials published up to December 2001. The analysis pooled odds ratios (OR) and associated confidence intervals (CI) using a fixed-effects model. The efficacy outcomes considered are responses (both partial and complete) and progressive disease. Grade 3 and 4 toxicities are considered using the WHO criteria for the following adverse events: alopecia, nausea and vomiting, anaemia, neutropenia, thrombocytopenia and neuropathy. RESULTS: Patients receiving Gemcitabine combined with a platinum therapy are more likely to experience a response to treatment than patients receiving other platinum based combinations. The OR for complete and partial responses is 2.68, (CI 1.53–4.67) and is 0.44 for progressive disease (CI 0.32–0.59). Gemcitabine patients experienced fewer cases of alopecia (OR 0.15, CI 0.10–0.22) and neutropenia (OR 0.6, CI 0.47–0.77). In contrast, Gemcitabine patients experienced a greater number of grade 3 or 4 anaemia (OR 1.92, CI 1.41–2.61) and thrombocytopenia (OR 6.76 CI 4.95–9.23) incidences. For neuropathy and nausea and vomiting there was no evidence for any of the chemotherapies having fewer patients experiencing toxicities. CONCLUSIONS: The implications of this analysis at the patient level is that if response is of primary importance, then on a purely clinical basis Gemcitabine should be the treatment of choice. Gemzar based chemotherapy had a higher number of responses and fewer adverse events for alopecia and neutropenia. To validate these results, a meta-analysis should be conducted with stratification for key variables using patient level data.

CANCER CHEMOTHERAPY AT HOME: FEASIBILITY, PATIENT OUTCOMES, AND HEALTHCARE SYSTEM IMPLICATIONS

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OBJECTIVES: At the Quebec Health Technology Assessment Agency (AETMIS) in Canada we assessed whether home chemotherapy for cancer was effective, safe, and satisfactory to patients, and examined the cost, organizational, and ethical implications, in order to make policy recommendations. METHODS: We carried out a systematic review of the scientific literature using the PubMed (MEDLINE 1980–present) and CancerLit (1975–present) bibliographic databases. We supplemented this review with 16 semi-structured interviews with service providers, including oncology nurses, physicians, and home care coordinators, in 2 provinces with different organizational structures for cancer care (Quebec and Ontario). RESULTS: Clinical effectiveness of home cancer chemotherapy appears similar to that in non-home settings. Home treatment can be delivered safely if patients are carefully selected and trained. Patient eligibility criteria relate to learning capability, suitability of the home environment, and geographic accessibility. Improvements in patient quality of life at home have not been well documented in the literature. Patient preference and satisfaction with home therapy is supported, although mostly among self-selected groups. Cost studies show that home chemotherapy is less expensive than inpatient treatment from a hospital perspective. When home treatment is used as a substitute for outpatient therapy, the result tends to be a cost shifting from hospitals to home care organizations. Effects on costs to patients/families require more study. Interviews with service providers showed variable delivery, with greater patient load capacity and uniformity of services where hospital oncology departments or regionalized centres