Regional, CRC-Distant, and Dead. Quality adjusted life years were used as the primary outcome measure. The base case analysis represents the overall cost and effectiveness associated with each screening strategy. Incremental cost-effectiveness ratios (ICERs) were calculated for each screening strategy. One-way sensitivity analyses were performed to assess the factors that have the greatest effect on the cost-effectiveness of screening. **RESULTS:** The most cost-effective screening strategy was Fecal Occult Blood Test (FOBT); followed by FOBT plus aspirin, colonoscopy, and colonoscopy plus aspirin. The ICER of FOBT was $13,014.85 compared to natural history or no intervention. The model was sensitive to the costs of FOBT, colonoscopy, and aspirin. The screening strategies were sensitive to the cost of aspirin, FOBT, and colonoscopy. **CONCLUSION:** Results from the analysis showed that the most cost-effective screening strategy was the use of FOBT yearly. In terms of only cost, FOBT was the least expensive screening strategy whereas the most expensive was colonoscopy plus COX-2 inhibitor. The results from the study suggest that FOBT and colonoscopy, as well as these strategies plus aspirin, are the more cost-effective of all the screening strategies employed. FOBT plus aspirin and colonoscopy have similar cost-effectiveness with colonoscopy having an ICER of only $35.43.

PCN13

COST-EFFECTIVENESS ANALYSIS OF DOCETAXEL VERSUS OTHER REGIMENS IN THE ADJUVANT THERAPY OF EARLY AND LOCALLY ADVANCED BREAST CANCER IN POLAND

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OBJECTIVES: To compare cost effectiveness of docetaxel chemotherapy with other adjuvant treatment regimens in early and locally advanced breast cancer. **METHODS:** Cost-effectiveness Markov model from payer perspective (health insurance and patient), using costs information from published sources and the patient lifetime horizon. **RESULTS:** Two comparisons, TAC (docetaxel/doxorubicin/cyclophosphamide—75/50/500 mg/m2, 6 cycles) vs FAC (fluorouracil/doxorubicin/cyclophophamide—500/50/500 mg/m2, 6 cycles) and FEC + T (fluorouracil/epirubicin/cyclophosphamide—500/100/500 mg/m2, 3 cycles + docetaxel 100 mg/m2, 3 cycles) vs FEC (fluorouracil/epirubicin/cyclophosphamide—500/100/500 mg/m2, 6 cycles), were performed. One randomized clinical trial was included for each comparison. Average costs of the treatment of early or locally advanced breast cancer (including adjuvant chemotherapy, additional treatment—tamoxifen/radiotherapy, treatment of adverse events and disease recurrence) and treatment effects were per patient: TAC 42883 PLN/25,7 LYG vs FAC 8799 PLN/23,6 LYG; FEC + T 32828 PLN/26,1 LYG vs FEC 13505 PLN/24,7 LYG. ICER for TAC vs FAC comparison was 16558 PLN/LYG. ICER for FEC + T vs FEC was 13 904 PLN/LYG. **CONCLUSION:** Docetaxel regimens are more effective and more expensive in the treatment of patients with early and locally advanced breast cancer compared with FAC and FEC chemotherapies, ICER range 13904-16558 PLN/LYG.

PCN14

PHARMACOECONOMIC ANALYSIS OF TREATING ADVANCED GASTRIC CANCER (AGC) WITH CAPECITABINE/CISPLATIN (XP) VS. 5-FU/CISPLATIN (FP) REGIMENS IN AN ITALIAN SETTING

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OBJECTIVES: A recent randomized phase III trial of XP vs. continuous infusional FP as first-line therapy in patients with AGC met its primary endpoint of non-inferior progression-free survival (PFS). There was a trend toward superior efficacy seen with the superiority test for PFS (median 5.6 months for XP vs. 5.0 for FP) and the superior response rates of XP. A pharmacoeconomic model was built to compare costs of the two therapies in an Italian setting. **METHODS:** Direct medical costs during the study were estimated from the Italian hospital perspective. Costs of the two alternative therapies were estimated based on the trial results on actual dose and the number of administrations, and Italian unit costs. Adverse event (AE) profiles were used to estimate the cost of treating AEs. An expert panel estimated typical treatment patterns and costs of treating major AEs like anemia and febrile neutropenia. **RESULTS:** AE profiles were similar: associated costs to treat major (grade 3/4) AEs were <€170 per patient and were lower in the XP arm. Patients in the XP arm received 5.2 cycles of therapy vs. 4.6 cycles of FP. The substitution of oral capecitabine for infusional 5-FU reduced the number of hospital clinic visits by 17.6 (22.8 for FP vs. 5.2 for XP). Chemotherapy drug costs were estimated to be €1200 greater with XP, but drug administration costs were €2900 lower, yielding a net cost saving of €1700 per patient. **CONCLUSION:** Oral capecitabine in combination with cisplatin would produce significant direct medical cost savings from an Italian payer perspective. AE costs are similar with the two regimens. Given the trend to superior efficacy, the projected direct cost savings, and the convenience of oral treatment, XP would be considered a dominant (less costly and more effective) regimen for AGC from the Italian payer perspective.

PCN15

COST-EFFECTIVENESS OF NEW TARGETED THERAPY SUNITINIB MALATE AS SECOND LINE TREATMENT IN METASTATIC RENAL CELL CARCINOMA IN ARGENTINA

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OBJECTIVES: To estimate the cost-effectiveness of sunitinib malate versus palliative/best supportive care (BSC) in the treatment of cytokine-refractory metastatic renal cell carcinoma (mRCC) in patients failing on IL-2, interferon-alpha or combination of these. **METHODS:** A Markov model was developed and adapted to Argentinean circumstances. Effectiveness results were taken from a clinical trial and a US Medicare database. Data was adjusted with general population mortality estimates from Argentinean life tables. Utilities were collected with the help of EQ-5D questionnaire in the clinical trial. The main source of resource use and unit costs was an Oncology Institute in Argentina. Costs were calculated in 2006 Argentinean pesos (AR$). Both costs and effectiveness were discounted at a 3% annual rate. Incremental cost-effectiveness was calculated for progression-free month (PFM), life-year saved (LYS) and quality adjusted life years (QALY). Both deterministic and probabilistic sensitivity analyses were undertaken for effectiveness and cost variables. **RESULTS:** Compared to BSC, sunitinib resulted in 2.61 extra PFM, 1.32 LYS and 0.98 QALY; however, at an additional cost of AR$52,243. The cost of gaining one PFM, LYS and QALY was AR$9596, AR$39,518 and AR$53,445 respectively. The result was most sensitive to effectiveness parameters. The incremental cost/QALY was always under the US threshold of $50,000. **CONCLUSION:** Though treatment with sunitinib