Abstracts

latory care sector the cost decreases over the four years. Every year the net budget impact due to Aprepitant is less than 3%. The fourth year, the treatment cost with Aprepitant is equal to €4,787,000. CONCLUSION: The additional costs caused by the introduction of Aprepitant seem fair compared to the gain in terms of complete control of vomiting.

COST ANALYSIS OF 3-YEARS FOLLOW-UP OF A TRASTUZUMAB TREATED COHORT

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OBJECTIVES: To evaluate the economic impact of trastuzumab treatment in Metastatic Breast Cancer (MBC). Trastuzumab therapy is initiated in MBC patients over-expressing HER2. The product is licensed in monotherapy for patients pre-treated with anthracyclines and taxanes, or associated with paclitaxel for patients pre-treated by anthracyclines. METHODS: HERMES is a phase IV multicentric prospective study funded by the French ministry of health, evaluating the clinical, biochemical and pharmaco-economic aspect of trastuzumab treatment on MBC. HER2 status was determined by Immuno-histochemistry or FISH methods and H-ECD (HER2 Extra-Cellular Domain) status by ELISA technique. Only HER2 3+ or 2+ and FISH+ patients received treatment. Four protocols were administered: trastuzumab + paclitaxel weekly (TP1) or three weekly (TP3) and trastuzumab weekly (T1) or three weekly (T3). Responses were evaluated according to RECIST criteria then compared to H-ECD levels. Treatment costs were calculated by adding DGR costs (2004) and onerous drug reimbursed over DGRs.

RESULTS: In a 3-years period, 120 patients were pre-included and 88 included. In intention to treat there were 62 TP1, 25 TP3, and 1 T1. Time to Treatment Failure is 30 weeks [23–35]. 81 patients stopped treatment: 67% for progression, 16% for cardiac toxicities. Overall survival is 60 weeks [48–80]. Time to Progression is 34 weeks [27–43]. After 2 months, on 27 patients, relative risk of progression is of 2.2 for patients with H-ECD increase. On 22 patients with H-ECD diminution, 20 were responding to treatment. Overall patient management cost is of €4,178,000. Average pre-inclusion screening cost is of €829 per patient. Average treatment cost on 36 weeks reaches €46,345 per patient including 72% for drug acquisition, 23% for administration, 1% for laboratory assessments, 3% for cardiac assessment, 1% for tumour volume assessment. CONCLUSIONS: From an economic perspective, HER2 assays are cost effective: €46,345 per patient per day. Costs for hospital stay accounted for the largest portion (€46,853%). Costs of pain therapy averaged out €8 (15%), €4 (42%) was analgesic costs and €4 (51%) application costs. Daily adverse-event management accounted for €1 per patient. CONCLUSIONS: Costs for the hospital stay to initiate transdermal opioid therapy were the major cost driver from hospital provider perspective. Although constipation and emesis prophylaxis is recommended by pain management guidelines, in clinical practice a substantial portion of patients didn’t receive adequate prophylaxis.

COST COMPARISON ANALYSIS OF INTRAVENOUS VERSUS COMBINED INTRAVENOUS-ORAL CHEMOTHERAPY IN ADVANCED NON-SMALL CELL LUNG CANCER

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OBJECTIVES: To compare costs of intravenous versus intravenous-oral application of cisplatin-etoposide (PE) and cisplatin-vinorelbine (PN) recommended in NSCLC treatment in Poland. METHODS: The data of medical resources consumed were collected retrospectively in three major oncology centers in Poland; among patients with advanced NSCLC (stage IIIb and IV), treated with intravenous regimen of PE or PN. The payers perspective were used and direct medical cost were assessed. All medical care consumption in intravenous regimen was estimated from the patients’ medical chart and the information of costs were derived from the medical valuation system used by National Fund of Health in 2005. All cost were in polish zloty (in 2005: $1 = 3.35 zloty). The resources consumption in combined intravenous-oral regimen was simulated basing on therapeutic guidelines of oral regimen of analyzed chemotherapy. We assume that patient was given intravenous therapy on 1st day (in both schemes) and oral dose instead of intravenous the following days. Such combination let to reduce the number of hospitalizations due to cytostatics application. RESULTS: The total costs of PN scheme in intravenous and combined regimen for one patient was the same and amount to ZL23,416, which means the savings due to hospitalization were compensate by increased dose of oral vinorelbine. Despite the increased dose of oral etoposide the 1228zl difference between intravenous and combined application was found in PE scheme. The total costs of treating NSCLC using intravenous and combined PE regimen were 12,660zl and 11,432zl respectively. CONCLUSIONS: Our analysis showed that both combinations of intravenous-oral chemotherapy could be considered as alternatives for intravenous regimens.