comes in terms of resource use and costs, especially when withdrawal rates differ between treatment groups. The aim of this study was to compare the impact of various methods for dealing with censored data on the total costs and on the difference in costs between treatment groups. **METHODS:** Five methods for dealing with censored data were applied to data from 519 patients with chronic disease participating in a one-year randomized clinical trial. These five methods are complete case analysis, linear extrapolation, hot-decking, predicted regression, and multiple imputation. **RESULTS:** Fifteen percent of the patients in treatment group A and 21% of the patients in treatment group B withdrew from the study before the scheduled end date. Mean costs per patient varied from €889 (SE: 94) in the complete-case analysis to €1400 (SE: 189) after predicted regression. Cost differences between treatment groups varied from €14 in the complete-case analysis, to €243 after multiple imputation, to €372 after predicted regression. Hot-decking, multiple imputation and predicted regression were sensitive to the selection of covariates. **CONCLUSION:** The various methods had a considerable impact on total costs and on the difference in costs between treatment groups. In economic evaluations more attention should be paid to methods for dealing with censored patients and the impact of these different methods on the CE-ratio.

**THE COST OF UPPER GASTRODUODENAL ENDOSCOPY: AN ACTIVITY-BASED APPROACH**

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**OBJECTIVE:** The cost of medical procedures is often unknown, but is nevertheless crucial for setting reimbursement and health-care policies. This study investigated the cost of an upper gastrointestinal endoscopy in ambulatory adults in a large academic hospital in the province of Québec, Canada from the perspective of the hospital. **METHODS:** An activity-based costing methodology was used to break down the endoscopy procedure into a number of primary tasks to which were allocated resources used at the department level (labor, equipment, and materials). Unit costs per activity were calculated from detailed tracking of items and factors used for performing each task. **RESULTS:** The direct cost of performing an endoscopy ranged from 62$Can (1Can$ = 0.75 EUR) for an undated, unbiopsied patient to 89$Can for a sedated, biopsied patient. Not included in this amount are separate reimbursement fees of 15$Can for biopsy analysis and 50$Can professional fees for the performing physician, which are charged directly to the Ministry of Health. A cost-volume function was constructed under two different hypotheses of divisibility (sharing between clinical units) or undivisibility of fixed equipment. This showed an optimal unit cost per procedure starting at around 3000 procedures a year for the installed equipment. Incorporating institutional overhead raises the cost of the procedure substantially by an amount of 41$ as does the use of non-reusable biopsy forceps, which adds about 63$Can to the total cost of the procedure. **CONCLUSION:** Given the high proportion of overall hospital-wide overhead in the total cost of the procedure, allocation methods for these overheads in current hospital accounting systems should be improved in order to obtain more precise estimates of the full cost of medical procedures like upper gastrointestinal endoscopy.