compare return to baseline (RTB) for HRQoL. A seven point difference (considered to be clinically significant) between baseline and follow-up score was considered as RTB. RESULTS: ANOVA indicated that RP group had higher scores for generic HRQoL subscales of physical function (p = 0.019), role emotional (p = 0.037), vitality (p = 0.033) and general health (p = 0.05). Step-wise log-linear regression models showed that RP was associated with higher 12 month scores for most of the generic HRQoL scales, bowel function (OR = 1.12), urinary bother (OR = 1.6) and bowel bother (OR = 1.5). For generic HRQoL (SF-36) at 12 month follow-up, higher proportion of the RP group returned to baseline on eight sub-scales. RP group had lower proportion returning to baseline for urinary (p = 0.0012) and sexual (p = 0.0001) functions, and higher proportion returning to baseline for bowel function, urinary bother and bowel bother (p = 0.003). Satisfaction with care was comparable between treatment groups. CONCLUSIONS: Older patients appear to have better tolerance for RP as indicated by patient reported outcomes. Thus age alone need not be a criterion in treatment decision.

PCN73

VARIATIONS IN SATISFACTION WITH CARE AND EMOTIONAL WELL-BEING OF EARLY-STAGE PROSTATE CANCER PATIENTS
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OBJECTIVE: To compare self-reported satisfaction with care and emotional well-being of newly diagnosed prostate cancer (PCa) patients receiving either Radical Prostatectomy (RP) or External Beam Radiation Therapy (EBRT). METHODS: The study was part of a larger prospective cohort study. We recruited 231 newly diagnosed African-American and Caucasian PCa patients from urology clinics of an urban academic hospital and a VA hospital. Patients completed the Client Satisfaction Questionnaire (CSQ-8), SF-36, FACT-p and UCLA-PCI prior to their treatment and at 3, 6, and 12 month follow-up. Demographic and clinical data were obtained from hospital based databases. Parametric and nonparametric tests were used to compare demographic, clinical characteristics and FACT-p subscales between treatment groups. Log linear regression models were used to assess factors associated with satisfaction. RESULTS: The RP group was younger (p < 0.0001), had a higher proportion of Caucasians (p < 0.0001), and were more like to be married (p < 0.0001), have incomes greater than $40,000 (p < 0.0001) and be employed full-time (p < 0.0001). Gleason score, TNM stage and Charlson comorbidity score were comparable by groups. Higher number of EBRT group reported poorer outcome measures on emotional well being subscale of FACT-p, compared to RP group. A higher proportion of RP patients indicated that they were likely to recommend the treatment to a friend (p = 0.0244) and that they would seek the same treatment if needed again (p = 0.0328). ANOVA of total CSQ8 score indicated significant differences between the groups and over time (p = 0.0059 and 0.0228, respectively). Log linear regression showed that RP treatment (OR = 1.13, p = 0.045), baseline PSA (OR = 0.98, p = 0.0062) and VA hospital (OR = 0.84, p = 0.0299) were associated with total satisfaction with care. CONCLUSION: EBRT, higher baseline PSA and non-VA hospital type are associated with lower satisfaction with care of PCa patients at 12 months post-treatment.

PCN74

UTILITIES ASSOCIATED WITH NON-SMALL CELL LUNG CANCER (NSCLC): A COMMUNITY STUDY
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OBJECTIVE: Exploring impact of NSCLC on quality of life (QOL) by eliciting utilities from a community sample. Non-small cell lung cancer (NSCLC) and its treatment both have a substantial negative effect on QOL. Little published research quantifies these effects in advanced disease. METHODS: Health state descriptions were developed from the literature and refined through clinician interviews (n = 6). Treatment response, stable disease, progressed disease, near-death and adverse events (AEs): neutropenia, febrile neutropenia, nausea, diarrhoea, stomatitis, neuropathy and rash were described. The impact of oral versus intravenous (IV) medication was also explored. A total of 154 lay people across the UK (Glasgow, Oxford, London, Cardiff) were presented with information on NSCLC. Health states, presented randomly, were valued using the EQ-5D. These values were converted to utilities for each health state. RESULTS: All health states were associated with low utility values. The utility value for near-death was the lowest (0.15) and that for treatment response the highest (0.49). There was no statistical difference between treatment response and stable disease (0.46). Stable disease receiving IV therapy had a significantly lower utility (0.43) than stable disease with no treatment; stable disease receiving oral therapy (0.45) did not. The utility value associated with progressed disease (0.22) was closer to that for near-death. Utilities for AEs were valued relative to the stable disease state. The greatest disutility was associated with febrile neutropenia (−0.27) and the lowest with rash (−0.06). Disutilities associated with other AEs were neuropathy (−0.13), neutropenia (−0.14), nausea (−0.14), stomatitis (−0.14) and diarrhoea (−0.13). CONCLUSIONS: Societal valuation showed that all disease states and AEs associated with NSCLC have a substantial impact on QOL, with disease progression, febrile neutropenia and near-death having the greatest impact. Treatment related rash is the least serious adverse event. Stable disease is associated with a better QOL than progressed disease.

INFECTION

CLINICAL AND ECONOMIC IMPACT OF INTRODUCING A QUADRIVALENT (6, 11, 16, 18) HUMAN PAPILLOMAVIRUS VACCINE IN SWITZERLAND
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OBJECTIVES: Human Papillomavirus (HPV) is a necessary cause of cervical cancer (CC). To date, CC screening programmes have been the only tool to help prevent CC by detecting and removing precancerous lesions. With the expected licensure of a quadrivalent HPV vaccination, a decision analysis model was developed to quantify the health and economic benefits of a quadrivalent (6, 11, 16, 18) HPV vaccine alongside CC screening in Switzerland. METHODS: The vaccine was considered to prevent 100% of HPV 6, 11, 16 and 18-associated diseases, with lifetime duration of protection and 40% coverage rate, when given to girls at age 12. Resource consumption included physician visits, medical examinations, treatments and hospitalisations. Data for management of abnormal pap smears, cervical dysplasia and genital warts were estimated by Swiss experts.
A COST–BENEFIT ANALYSIS OF DIFFERENT VARICELLA VACCINATION STRATEGIES INVOLVING ITALIAN CHILDREN AND ADOLESCENTS

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OBJECTIVES: To assess the potential epidemiological, clinical, and economic effects of different varicella vaccination strategies in Italy, involving children and adolescents. METHODS: The simulation model EVITA (Banz et al. 2003) was developed to analyse universal varicella vaccination strategies. Epidemiological and economic model input data were collected from Tuscany region data banks and the available Italian literature. The vaccination strategies analysed included: 1) 1–1.5 y (years), 85% coverage; 2) 1–1.5 y + catch-up 12 y (1 dose, 30% catch-up coverage); 3) 1–1.5 y + catch-up 13 y (2 doses, 30% coverage); and 4) 1–1.5 y with 2 doses + catch-up 13 y (2 doses, 30% coverage). Analysis time horizon was 30 years. RESULTS: Without universal vaccination, the model predicted 501,644 varicella cases and 27,341 related complications in Italy each year. All vaccination strategies resulted in excellent clinical outcomes, with strategy 2) being the most effective, preventing over 83% of varicella cases and complications. A low coverage scenario (50%) prevented only 68% of varicella cases, with a rebound of cases occurring after around 15 years of initial decline. Average yearly cost savings for strategy 2) are 62 million Euros for the society and 2.3 million Euros for the NHS, and for the 1) strategy 59.7 and 2.5 million Euros, respectively. The most favourable clinical and economic outcomes of a catch-up programme occurred when vaccinating 12 y adolescents with 1 dose instead 13 y adolescents with 2 doses. Only strategy 4) failed to generate savings for the NHS. No significant differences in outcomes were detected when using epidemiological and seroprevalence data corresponding to North, Centre and South of Italy. CONCLUSIONS: Universal varicella vaccination in children (with or without an adolescent catch-up programme) is very effective in reducing the high burden of disease and leads to significant cost savings.

COST–EFFECTIVENESS ANALYSIS OF TONSILLOPHARYNGITIS AND RHYNOPHARINGITIS ACCUTA, ANTIBIOTIC TREATMENT, SRBIJA, NIS REGION

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OBJECTIVES: Identification of cost–effectiveness antibiotic treatment method tonsilopharyngitis and rhynopharingitis accuta in pediatric population from just born to 12 years old children in which these diagnosis were establish on the level of private and government primary health care practice system, depending of clinical report and possible drug hypersensitivity. METHODS: Cost–effectiveness analysis was done in two different periods of time; The first one was before establishing “The National guide for antibiotic treatment”, and the second one after that. Four possible treatments with 30 children each were observed. These are following–before the implementation of the National guide 1) Phenoxymethylpenicillin oral suspension (300,000 IU/5 ml 10 days); 2) Erythromycin oral suspension (200 mg/5 ml 5 days); 3) Benzylpenicillin procainpencillin inj i.m. (800,000 IU 7 days); 4) Lincomycin inj i.m. (600 mg/2 ml 7 days). After 1) Amoxicilin + clavulonic acid oral suspension (7 days); 2) Azithromycin oral suspension (200 mg/5 ml 4 days); 3) Benzylpenicillin procain-pencillin inj i.m.; 4) Phenoxymethylpenicillin oral suspension. Real costs were calculated for each possible treatment contains direct (first doctor visit, control check up, medicines and OTIC therapy costs), indirect (additional treatment payment and eventual complication payment). Patients were sorted in those with completely, partly successful and total unsuccessful treatment. ICER (Incremental cost effectiveness ratio) was defined for each possible treatment; base was number of days without refreshing infection. Comparison of ICER value gave cost effectiveness therapy. RESULTS: ICER showed for the first period that Benzylpenicillin procainpencillin inj i.m. (7 days) was the best cost effectiveness treatment. In addition The National guide confirmed and recommended it also. On the contrary, after implementation of the National guide the most prescribing treatments were Amoxicilin+clavulonic acid oral suspension (7 days) and Phenoxymethylpenicillin oral suspension (10 days). It doesn’t reduce therapy costs. CONCLUSIONS: Prescribing practice in Serbia should be changed by using the most CE methods and that will cause decrease in total costs of antibiotic therapy.

ANTIBIOTIC THERAPY OF NOSOCOMIAL INFECTION IN THE INTENSIVE CARE UNIT: A COST-EFFECTIVENESS ANALYSIS

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OBJECTIVES: To determine the cost-effectiveness of meropenem treatment versus standard strategy of antibiotic (AB) therapy for high-risk patients with nosocomial infection (NI) in the intensive care unit (ICU). METHODS: Two group high-risk patients with NI were randomly assigned to AB treatment: 1st—62 pts received meropenem (1.5–3 g daily) and 2nd—73 pts treated by standard AB therapy (combination of penicillins with or without a betalactamase inhibitor, cephalosporins III or IV generation, fluoroquinolons with aminoglicosides). Direct medical costs (cost of drug administration, resource utilization, duration of hospitalization) were estimated. Achievement of recovery was used as effectiveness. Unit costs were based on detailed data from the Moscow Obligatory Insurance Fond (2006). The rate of exchange was 34,44 rubles for 1 EUR. RESULTS: Direct medical costs were 1618.6 EUR for group 1 (C1) and 2065.7 EUR for group 2 (C2). Achievement of recovery—80.6% (E1) and 46.6% (E2) for each group respectively, p < 0.01. The final calculation of cost-effectiveness ratio (CER) was: CER1 = €20.08 and CER2 = €44.32 per every percent of recovered patients for group 1 and 2 respectively. CONCLUSION: Meropenem usage versus standard AB therapy is more effective from the position “cost-effectiveness” in the treatment of high-risk patients with nosocomial infection in the intensive care unit.