weight. The main objective is to conduct a pharmacoeconomic analysis to find out the cost effectiveness of Diethylthronic with diet and exercise. (DE+D), compared against Diet and Exercise (D) in Mexico. METHODS: The point of view of the study was the supply of IMSS health services. The target population were men and women over 18 years old with BMI ≥30 kg/m². Outcome measures were the reduction of weight in kg and Quality Adjusted Life Years (QALYs). The direct costs in the treatment of obesity were assessed, treatment of adverse events and complications (Type 2 Diabetes Mellitus and cardiovascular disease). We used a Dynamic, Stochastic Markov (DStM) and a univariate and probabilistic sensitivity analysis was performed. All the quantities expressed in Mexican pesos (MX$).

RESULTS: DE+D presented a lower cost and improved the utility and effectiveness when compared to D. Incremental cost was $16,285,000 in men and $16,285,000 in women. Incremental effectiveness and utility was 4.19 kg and 0.10 QALYs in men and 3.77 kg and 0.08 QALYs in women. ICER pointed the absolute dominance for DE+D. Estimated savings per 100 patients in the IMSS can be $1,697,027 MX$ if complemented by a 100% change health habits using DE+D. CONCLUSIONS: The combination of DE+D provides a cost effective improvement to the treatment of patients with a risk profile for obesity.

PSY22

ANALYSING THE BENEFITS AND COST SAVING OF ORAL VERSUS IV FLUDARABINE FOR MANAGEMENT OF B-CELL CHRONIC LYMPHOCYTIC LEUKAEMIA (CLL)

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OBJECTIVES: Fludarabine (F) is a mainstay treatment for CLL. Despite the availability of an oral formulation with equivalent efficacy and improved patient acceptability, many centres use an IV generic formulation assuming it is cheaper. A cost-minimization analysis was undertaken on the two formulations.

METHODS: The cost-minimization analysis compared oral F and combination Fludarabine and Cytarabine (FC). It included: European acquisition values defaulted to generic prices; body surface area 1.75m²; mg/m² dosages oral F 40, IV F 25, oral C 150, IV C 250; dosage days/cycle F 5 / FC 3 for 6 cycles/patient. Published adverse event rates were equivalent except for IV administration complications (8% default) and diarrhoea (oral F 34.6% vs IV F 11.3% - Grade 1-2 and 3.8% vs 0% - Grade 3-4) - 2% managed in hospital. Equipment and clinical resource costs were defaulted to published rates and authors' centres. A sensitivity analysis assessing minimum and maximum potential costs was applied.

RESULTS: Acquisition costs per treatment course were higher for oral F (IV $5,334 vs oral $3,131 FC - $3,213.16 vs $684). However IV costs increased with adverse events (oral vs IV complications mean 60 vs 60; diarrhoea 1% vs 60 and hospital resource costs (oral IV F $18 vs $4,00, FC $18 vs $2,520). Direct oral IV treatment costs per patient were $6,355 vs $5,553 (range $5,334-6,553 and $5,513-5,577, FC $3,352 vs $3,454 (range $3,214-3,233 and $3,414-4,478). Modelling oral adoption in 100 patients - 80% IV F / 20% IV FC, a 50% and 90% switch respectively resulted in $19,943 mean cost savings, releasing funding and resources for improved care and patient throughput.

CONCLUSIONS: Oral fludarabine is associated with a lower IV costs. However cost minimization modelling demonstrated reduced direct costs with oral fludarabine, while also being preferred by patients.

PSY23

ECONOMIC EVALUATION OF ERYTHROPOIESIS STIMULATING AGENTS IN CRITICALLY ILL TRAUMA PATIENTS

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OBJECTIVES: Recent randomized trials (RCT) have suggested erythropoiesis stimulating agents (ESA) reduce mortality in critically ill trauma patients; however ESA are costly. We sought to determine cost-effectiveness of ESA in this patient population.

METHODS: A decision analytic model was constructed to compare the use of ESA to standard care in trauma patients admitted to an intensive care setting. Base case costs and benefits at one year were estimated using mortality estimates from available RCTs. One way and probabilistic sensitivity analyses were conducted for comparison of the base case scenario with 10 and 25 year time horizons in Markov models.

RESULTS:ESA use was associated with a cost per QALY gained of $74,500 to $81,748 compared with standard care at one year. One way sensitivity analysis showed results were sensitive to changes in mortality risk, risk of thrombosis, relative risk of mortality, relative risk of thrombosis, and quality of life estimates. Cost effectiveness acceptability curves generated from probabilistic sensitivity analysis indicated that the probability ESA would be considered attractive ranged from 35% to 80% over the range of WTP of $60 to $120,000. Consideration of longer time horizons reduced the cost per QALY gained to $9,338 – $9,597.

CONCLUSIONS: While the cost per QALY gained with ESA use falls into the cost-effectiveness acceptability curve, particularly long-term survival benefit with ESA use. Further research into the efficacy and safety of ESA use in critically ill trauma patients is required to prior used.