PHARMACOECONOMIC ANALYSIS OF ADVANCED NON-SMALL CELL LUNG CANCER TREATMENT WITH DOCETAXEL-CISPLATIN, PACLITAXEL-CISPLATIN AND PACLITAXEL-CARBOPlatin

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OBJECTIVES: To compare the efficiency (the evaluation of efficacy in relation to costs) of three first-line treatment options for advanced non-small-cell lung cancer (stage IIIIB and IV) used in the ECOG study: docetaxel/cisplatin (75/75 mg/m²/day; 1 hour IV infusion of docetaxel); paclitaxel/cisplatin (175/75 mg/m²/day; 3 or 24 hour IV infusion of paclitaxel), and paclitaxel/carboplatin (175/400 or 225/400 mg/m²/day; 3 hour IV infusion of paclitaxel).

METHODS: The results of the ECOG 1594 phase III clinical trial demonstrated equivalent efficacy (survival, objective response) between the treatment options. To differentiate between the treatment options, we performed a cost-minimization analysis, using a pharmacoeconomic model.

RESULTS: The average estimated treatment cost per patient (median, four cycles) with docetaxel/cisplatin would be $1,067,836 (€7738 USD) with paclitaxel/cisplatin (3 or 24 hour infusions, respectively) and 1,365,304 or 1,439,369 Ptas (€8205 or €8651; 7340 or 7738 USD) with paclitaxel/carboplatin (175/400 or 225/400 mg/m²/day; 3 hour IV infusion of paclitaxel). Anti-androgens were used for 48 weeks and 43.8% and 31.3% of younger and in 40.2% and 36.8% of older patients.

CONCLUSIONS: The duration of LHRH agonist use by prostate cancer patients varies by age. Large proportions of patients in both age groups use CAB for <=24 weeks, suggesting use to protect against testosterone surge. Additional research is required to verify these results.

QOL CHANGE OVER TIME POST-REINFUSION OF PBPC IN HIGH DOSE TREATMENT OF NON-HODGKIN’S FOLLICULAR LYMPHOMA (N-HFL) WITH AND WITHOUT FILGRASTIM USE

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OBJECTIVES: To assess the quality of life (QoL) with Q-TwiST retrospectively in a randomised phase III trial...
with n-HFL patients comparing the use of filgrastim after peripheral blood progenitor cells reinfusion.

**METHODS:** Multi-centre study conducted in France between 1995-1999 including 51 patients (24 placebo (P) and 27 filgrastim (Fl)). Demographic, disease and treatment-specific information was collected through the CRF. QoL assessment per patient over 90 days of follow-up (FU) was calculated as follows. QoL-index valued from 0 (worst) to 1 (best) was used to assign QoL per hospital day: in sterile room (SR) = 0.6; in a normal room (NR) = 0.9. Each adverse event (AE) (WHO grade 3 or 4) affected the QoL index with an additional factor of 0.8, 0.6, 0.4 or 0.2 respectively for 1, 2, 3, 4 concomitant AEs per patient per day. Average QoL-scores over time per treatment arm were compared using Kaplan-Meier statistics (p < .05, two-sided). Sensitivity analysis on the score index over the FU was undertaken.

**RESULTS:** For Fl the average days with 0, 1, 2, 3, 4 AEs in a SR was 6.59, 4, 2.56, 0.81, 0.37 and in a NR, 1.59, 1.67, 0.56, 0.11, 0. For P in a SR we had respectively 8.3, 3.8, 2.8, 2.2, 0.125 and in a NR, 2.13, 0.9, 0, 0. Average estimated QoL-score was 81.71 for Fl (SD: 3.15, range: 72.54–85.24) and 80.66 for C (SD: 3.01, range: 71.8–84.68) (Mann Whitney U test: p = 0.49 but decreased to <0.25 for first hospitalization period). Kaplan-Meier graph demonstrates after day 16 a constant QoL benefit for FI due to earlier hospital discharge (Log rank test: 27.2; p < .001).

**CONCLUSION:** Filgrastim use 24 hours post-PBPC in high dose treatment of n-HFL patients is associated with QoL improvement due to earlier hospital discharge.

**ELAPSED TIME TO DISCLOSURE OF BRCA1/2 GENETIC TESTING RESULTS AND PARTICIPANTS’ DISTRESS: PRELIMINARY FINDINGS FROM A RESEARCH SETTING**

**OBJECTIVE:** It is assumed that genetic testing for breast-ovarian cancer predisposition in the context of peer-reviewed research protocols at academic centers offers protection against test-related distress. However, BRCA1/2 genetic testing under research protocols often implies a significant time delay before the test result can be disclosed, which would not apply to commercially available testing. Using data from our own research setting, we investigated whether delay in getting BRCA1/2 test results was associated with participants’ distress.

**METHODS:** Participants were 128 women from 26 French Canadian kindred with a BRCA1/2 germline mutation identified. Genetic counseling was provided in a pre-test education session and a result disclosure session. Of the women tested, 53 (41%) were found to be carriers of the familial mutation and 75 (59%), non-carriers. Mean age at enrollment (48.4 yrs ± 12.1) was similar for the two groups. Test-related distress was assessed by the Impact of Event Scale one month after result disclosure.

**RESULTS:** Time interval between blood sample for testing and result disclosure varied considerably (range: 35 to 756 days), and was similar for carriers (mean = 172 ± 120 days) and non-carriers (mean = 174 ± 174 days). Among non-carriers, those given their result less than six months following blood draw (n = 48) tended to have lower levels of test-related distress (mean = 3.3 ± 5.2) than those who were told their result beyond 6 months (n = 27, mean = 7.8 ± 11.2, p = 0.06). For carriers, test-related distress did not differ according to whether they were given their result less than six months (n = 35, mean = 10.4 ± 13.7) after the blood draw or later (n = 18, mean = 9.8 ± 12.2).

**CONCLUSIONS:** Consistent with others, these results indicate that most women cope well with test information in research settings with careful expert counseling. Nevertheless, our findings among non-carriers suggest that prompt disclosure of BRCA1/2 test results has potential quality-of-life benefits.