obtained from Ministry of Health Drug Price List, Price List of Social Security Institution Health Implementation Guideline Appendix 2/D and 8, respectively. Clinical and economic outcomes: The clinical outcome measure is the proportion of patients responding. The model takes into consideration all of direct costs associated with the treatment, i.e. antifungal medications, treatment of side effects and tests. Because the time horizon of the model is shorter than 1-year, costs are not discounted. RESULTS: Total costs and response rates are €2,560/0.40, €8,900/0.47 and €3,790/0.32 for itraconazole, voriconazole and amphotericin-B, respectively. When compared with amphotericin-B, additional response rate that is gained with voriconazole is 0.08. This gain is obtained with €1230 less cost. Incremental response rate that is gained with voriconazole is 0.07. This gain is obtained with €6,330 extra cost, i.e. incremental cost-effectiveness ratio (ICER) is €91,000/response. One-way sensitivity analyses prove that results of the study are strong. CONCLUSIONS: In the treatment of aspergillosis, itraconazole is the dominant therapy in comparison to amphotericine-B. Compared to voriconazole, itraconazole is the cost-effective therapy option with the ICER of €82,800/ response for voriconazole.

PHARMACOECONOMIC EVALUATION OF PARENTERAL ITRACONAZOLE USE IN THE PROPHYLAXIS OF INVASIVE FUNGAL INFECTIONS IN TURKISH SETTING
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OBJECTIVES: Since mortality rate due to invasive fungal infections (IFI) associated with febrile neutropenia (FN) is very high, empirical antifungal treatment is the mainstay of treatment in patients with FN. The aim of the study is to compare the cost-effectiveness of parenteral itraconazole with amphotericin-B in empirical treatment of IFIs in cancer patients with FN. METHODS: Model: Decision tree modeling is used in the calculation of cost-effectiveness of options. The time horizon considered in the model is 20 days. The study has been performed from the health care payer perspective. Patient group: Cancer patients older than 18 years, with persistent fever despite anti-infective treatment. Data sources: The clinical data are acquired from published clinical studies. Resource use data are based on expert panel. Prices of medications, institutional discount rates and other costs related to the treatment obtained from Ministry of Health Drug Price List, Price List of Social Security Institution Health Implementation Guideline Appendix 2/D and 8. Clinical and economic outcomes: Clinical outcome is response to the treatment. Direct medical costs that are considered are the costs related with antifungal treatment and side effects. Because the time horizon of the model is shorter than 1 year, costs are not discounted. The results are presented as additional cost per additional response (ICER). Number-needed-to-treat (NNT) values are also calculated. RESULTS: Response rates are 0.59 and 0.61, and total costs are €2460 and €2773 for itraconazole and amphotericin-B, respectively. ICER is calculated as €14,898/response rate for amphotericin-B. NNT values are 1.69 and 1.64 for itraconazole and amphotericin-B, respectively. A total of €390 will be saved for equal clinical outcome, if itraconazole is used instead of amphotericin-B. One-way sensitivity analyses prove that the results of the study are strong. CONCLUSIONS: Itraconazole is a cost-effective treatment modality in the empirical treatment of IFIs in FN patients in Turkey.