gested by these clinical experts. The resulting health states (n = 17) were piloted and used in a societal-based valuation study (n = 100). Participants rated half of the total health states in a standard gamble interview to derive health state utility scores. Data were analysed using a mixed model analysis. This study was conducted in line with standard NICE appraisal methodology.

RESULTS: All tumour response statuses and toxicities were independent significant predictors of utility (p < 0.001). Stable disease with no toxicity (our base state) had a utility value of 0.65. Utility scores ranged from 0.67 (responding disease with no toxicity) to 0.47 for progressive disease.

CONCLUSION: This study reflects the value that society places on the avoidance of disease progression and severe toxicities associated with the treatment of second-line advanced NSCLC.

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RELIABILITY AND VALIDITY OF HEALTH UTILITIES INDEX (HUI) SCORES FOR SURVIVORS OF BRAIN TUMORS IN CHILDHOOD: AGREEMENT BETWEEN PATIENTS AND PARENTS

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OBJECTIVES: Assess inter-rater agreement (patient and parent) of HUI utility scores for survivors of brain tumors in childhood.

METHODS: Patients and their parents were interviewed twice using an interviewer-administered HUI questionnaire. Agreement was assessed using intra-class correlation coefficients (ICC). T-tests assessed the statistical significance of differences in mean overall and pain utility scores between patients reporting no pain and those reporting pain.

RESULTS: HUI data for 40 brain tumor survivors (57.5% female) were collected during late 2000 and early 2001 (interview 1). To date, 26 re-assessment interviews have been completed during 2005–2006 (interview 2). One patient has died. Patient mean age was 6.8 years at diagnosis and 16.2 years at the first survey. For overall health-related quality of life scores (HRQL), there was substantial inter-rater agreement (HUI3 ICC = 0.723, p < 0.001) at interview 1 and moderate agreement (HUI3 ICC = 0.561, p = 0.03) at interview 2. There was substantial to almost perfect agreement at both interviews for attributes considered readily observable (vision, speech, ambulation and dexterity) (ICC 0.783 to 0.988, p < 0.001). For less observable attributes (emotion, cognition, pain), agreement was moderate or less (ICC from 0.101 to 0.611, p = 0.372 to 0.002). Statistically significant differences were detected for both mean HRQL (difference = 0.36, p = 0.003) and pain (difference = 0.24, p = 0.003) scores between patients reporting pain (n = 14) and those pain free at interview 1. At interview 2, the mean scores were not statistically significantly different between patients reporting pain (n = 7) and those with no pain (n = 19, HRQL p = 0.317; pain attribute p = 0.067).

CONCLUSIONS: There was moderate or better inter-rater agreement for HRQL and all readily observable single-attribute HUI3 scores both at interview 1 and interview 2. Levels of ICC are consistent with previous studies of childhood cancer survivors in Brazil and Uruguay. Differences in mean HRQL and pain scores between patients with and without pain is evidence of discriminative validity.