

did not show significant differences over time when evaluated in the same fashion.

Table 1: Change in QOL Scores over time by Marital Status for EC Patients

	Married (N = 180)	Single (N = 31)	p value
Fatigue	-0.4	-0.6	0.64
Finance	0.4	0.8	0.36
Legal	0.2	1.1	0.04
Overall Emotional	0.1	0.4	0.63
Overall Mental	0.1	0.3	0.61
Overall Physical	-0.4	0.7	0.02
Pain Frequency	-0.9	0.6	0.03
Pain Severity	-0.6	0.2	0.10
Social Activity	-0.1	0.0	0.90
Spiritual	0.0	0.3	0.42
Family/Friend Support	-0.2	0.1	0.13
Overall QOL	-0.3	0.3	0.24

Positive values indicates improvement

1108 **Health-related quality of life (HRQOL) and kidney cancer-related symptoms in patients with metastatic renal cell carcinoma (mRCC) treated with sunitinib versus interferon (IFN)-alpha: results for European and US subsample analyses in a randomized, multinational phase III trial**

POSTER

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Background: Sunitinib malate is an oral, multitargeted tyrosine kinase inhibitor of VEGFRs, PDGFRs, KIT, RET and FLT3, with antitumor and antiangiogenic effects. In an international, randomized phase III trial, sunitinib demonstrated statistically superior efficacy and HRQOL over IFN- α as first-line mRCC therapy ($P < 0.001$) [Motzer et al. NEJM 2007; 356: 115–24]. Here we explore the association between geography and treatment effect on patient-reported outcomes (PROs).

Methods: 750 mRCC pts were randomized 1:1 to sunitinib 50 mg PO QD in 6-wk cycles (4 wks on, 2 wks off) or IFN- α (9 MU SC TIW). HRQOL was measured by the Functional Assessment of Cancer Therapy-General (FACT-G) and its 4 subscales; the FACT-Kidney Symptom Index (FKSI) and its disease-related symptom subscale (FKSI-DRS); and the population-preference-based health state utility score (EQ-5D Index) and pt self-rated overall health state (EQ-VAS) from the EQ-5D self-report questionnaire. Pts completed questionnaires on days 1 and 28 of each cycle. Data were analyzed using repeated-measures mixed-effects models for the EU+ (France, Germany, Italy, Poland, Russia, Spain, UK, plus Australia and Canada; $n = 400$) and US ($n = 346$) subsamples.

Results: The overall post-baseline least-square means significantly favored sunitinib in all 9 PRO endpoints ($P < 0.05$), except EQ-5D in the US subsample (Table). Most of the 9 FKSI-DRS items also favored sunitinib (data not shown). These findings were consistent with the overall sample results. In general, the EU+ subsample had larger between-treatment differences.

HRQOL Endpoints	EU+ Subsample		US Subsample	
	Diff.*	P value	Diff.*	P value
FKSI	3.96	<0.0001	2.29	0.0007
FKSI-DRS	2.55	<0.0001	1.26	0.0009
FACT-G total score	6.01	<0.0001	4.56	0.0002
Physical well-being	1.56	0.0005	1.12	0.0148
Social/family well-being	1.33	0.0001	0.80	0.0269
Emotional well-being	0.80	0.0197	0.64	0.0363
Functional well-being	1.97	<0.0001	1.75	0.0003
EQ-5D index (utility score)	0.05	0.0066	0.01	0.4105
EQ-VAS	4.98	0.0004	4.01	0.0224

*All results favor sunitinib.

Conclusions: Sunitinib offers consistent HRQOL and kidney cancer-related symptoms advantages compared with IFN- α in the first-line treatment of mRCC for pts in both Europe and the US. These advantages were more pronounced in the EU+ sample, possibly reflecting differences in treatment experience or underlying differences in HRQOL reporting.

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POSTER

Can the incentive system in health care create behaviour changes in patient treatment?

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(This work is part of a master of management study; economic understanding in leadership.)

The Norwegian government through national cancerplan St.prp nr 61 (1997–98) made available 7.3 billion NOK to a national cancerplan. One of the main goals was to increase the capacity and quality of radiation therapy to palliative patients. Norway has a incentive system in radiation therapy where the refund is connected to each beam field. And as we know, it is common that curative treatment uses many beams and fractions while palliative treatment uses few beams and few fractions. By these facts we can suppose that it is “bad business” to treat palliative patients with radiation therapy. But no one in Norway has estimated this exactly. By using ABC (Activity Based Costing) analysis (method) I wanted to estimate how the costing for polyclinical palliative and curative patients (undergoing radiation therapy) corresponds to the income from the refund system.

The ABC method is quite a new system to distribute indirect costs. Kooper (1998, pp. 79–80) define ABC as; “... an economic map of the organizations's expenses and profitability based on organizational activities ... An activity-based cost system provides companies with an economic map of their operations by revealing the existing and (...) forecasted cost of activities and business processes, which, in turn, leads to knowledge of the cost and profitability of individual products, service, customer, and operating units”.

351 patients were included in the project. That includes 5815 patient meetings in which 24,581 beams were given. Refund was 10,226,543 NOK plus a basis payment of 2,948,484 NOK. Total 13,175,025 NOK.

The total cost was estimated at 13,189,000 NOK. This includes wages of everybody working in the department, merchandise costs, electricity, cleaning etc. (write-downs on the building, the linac and other machinery was not included because it was given by the government).

The results show that the department

- has an undercoverage on each (average) polyclinical palliative patient of -10,232 NOK but
- has an overcoverage on each (average) polyclinical curative patient of +18,873 NOK

The project proves the hypothesis that it is “bad business” to treat palliative patients with radiation therapy. This is the opposite of the intention in the national cancerplan.

It is likely that this system gives palliative patients poorer treatment and less possibilities than if the refund system was better for this patients. That will be the next step to look into.

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POSTER

Management of anaemia in patient with cancer. Results of the F-FACT Study (French Anaemia Cancer Treatment)

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Background: anaemia is one of the most dreaded complications in patients with malignant pathologies. Its causes are varied and whatever its severity, the impact on the quality of life of the patient remains essential. This is why we carried out a large national survey with the goal to assess the prevalence and the management of anaemia in patients with malignant diseases.

Methods: the F-FACT (French Anaemia Cancer Treatment) study is a retrospective observational multicentric study conducted in 178 experts among 112 centers which treat patients with solid tumours and/or malignant haematological diseases. Assessment was performed over one day for each questioned expert.

Results: a total of 2782 patients were enrolled, including 1335 women (48%) and 1447 men (52%). The median age was 61 years (range: 18–93 years). There were 1892 (68%) patient with solid tumour and 890 (27%) patient with malignant haematological disease. The main sites of cancer localization were: breast (19%), colo-rectal (14%), lymphoma