

(cost difference of about 11%). The cost component 'day case' days contributes most to the total treatment costs of 5-FU + LV, and the cost component 'drugs and preparation' contributes most to the total treatment costs of Tomudex®.

**Discussion:** This research was based on the finding of equal efficacy of the two chemotherapy treatments. To determine the optimal treatment for society, Quality of Life must be invoked in economic evaluation. Because of a convenient dosing schedule, Tomudex® patients spend less time at the 'day case' department, travel less often to the hospital and thus are less time away from normal activities than 5-FU + LV patients. 5-FU + LV patients are more likely to suffer from severe mucositis and leucopenia than Tomudex® patients. This may influence patient's Quality of Life and thus warrants for further research, preferably a cost-utility analysis.

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#### OP12. Results of an economic evaluation of a RCT of routine follow-up after primary treatment for breast cancer: A comparison of primary care vs specialist care

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**Background:** It is standard practice in most countries to provide long-term routine follow-up after primary treatment for breast cancer in specialist oncology or surgical clinics. We hypothesised that routine follow-up under primary care would be equivalent but less costly than follow-up under specialist care. We conducted an RCT with concurrent economic evaluation to assess the effect of transferring primary responsibility for routine follow-up of women with early stage breast cancer from specialist care to primary care.

**Methods:** Patients were 296 prevalent cases with early stage breast cancer. They were randomised to continued follow-up in specialist clinics (control arm) or follow-up by their own general practitioner (GP arm). Patients in the GP arm were referred back to specialist care if diagnosed with recurrence or new primary cancer. The outcome measures were delay in diagnosing recurrence and health-related quality of life (HRQOL). A detailed cost analysis was conducted alongside the RCT. The perspective of the economic evaluation considered costs to the health service (particularly the costs of visits and diagnostic tests) and costs to the patient (direct costs, indirect costs and time taken for a follow-up visit).

**Results:** Most recurrences (18/26, 69%) presented between routine visits and almost half (7/16, 44%) of the recurrences in the control arm presented first to the primary care physician. There were no differences between groups in clinical or HRQOL outcome measures. Hence, a cost minimisation analysis was conducted. The cost analysis showed clear evidence that primary care based follow-up services were substantially less costly than specialist based follow-up services ( $p < 0.001$ ). Patients in the specialist group reported longer travel times, longer waiting times and less time with the doctor ( $p < 0.001$ ). Detailed results of the economic evaluation will be presented.

**Discussion:** Primary care follow-up of the women studied led to lower costs without any increase in time to diagnosis of recurrence or deterioration in health-related quality of life. If these results are replicated in other settings (a trial is currently taking place in Ontario), they suggest women with breast cancer should be offered a choice between specialist and primary care follow-up.

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#### OP13. Economics of the MRC Colorectal Working Party CR06 Trial

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**Background:** CR06 is a large nation-wide multi-centre trial being undertaken to compare three alternative chemotherapy treatments for patients with advanced colorectal cancer (de Gramont bolus and infusion, Lokich continuous infusion 5FU, and Tomudex) and to assess the optimum duration of treatment (stop versus continue treatment of patients whose disease has not progressed during the first 12 weeks of chemotherapy). There is, however, a growing awareness that health care resources are scarce and therefore in addition to determining comparative effectiveness in terms of clinical outcomes it is also important to consider at what cost these outcomes are achieved. In line with the main investigation, the health economics component of the trial will also address two issues; the comparative cost-effectiveness of continuing versus stopping chemotherapy after an initial 12 weeks of treatment. This will require data on resource use in addition to all other data being collected for CR06.

**Method:** The health economic data is being collected from a sub sample of centres taking part in the main trial. We have recruited 5 centres for this part of the study, spread geographically across the UK. Each centre provides all three chemotherapy regimes. Each of the alternative forms of chemotherapy delivery is provided in at least one centre. A total sub sample of approximately 150 patients will be obtained. Detailed data on the NHS costs of treatment are being collected from the five participating centres. This includes measurement and valuation of staff costs (medical, nursing, pharmacy), and costs of drugs and consumables for all regimes. A shorter questionnaire has been sent to all participating centres in the main trial to determine current methods of providing chemotherapy and obtain crude data on associated costs which will allow extrapolation of the detailed data across the whole trial. A research nurse in each of the five centres is monitoring via patient notes the investigations undertaken as well as any additional treatment. Patient borne costs are being collected by means of a weekly patient diary, completed by the patient or a relative. The diary monitors all costs incurred by patients or their families, including the opportunity cost of time taken off work both by the patient and by others to care for the patient. Differential use of general practitioner, district nurse or other health or social service resources between the groups is also being monitored in the diaries. Outcome data will be provided from the whole trial population on survival and quality of life measured on the EORTC QLQ-C30.

**Results:** From the data collected so far, it appears that the five centres chosen are representative of the sample as a whole, allowing extrapolation of the data.

**Discussion:** The extent to which detailed costing data can be collected from a sub sample of participating centres and extrapolated across the whole trial population is an interesting issue that requires further exploration.

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#### OP14. Diagnostic Imaging in Cancer. The Economics of PET

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**Background:** Positron Emission Tomography (PET) is a diagnostic imaging modality that differs from traditional technologies such as Magnetic Resonance Imaging (MRI) and Computed Axial Tomography (CAT) by evaluating function and biochemical process within the body rather than structural and anatomical indicators of disease. This gives PET the advantage of detecting cancer at an earlier stage and, by not restricting diagnosis to a specific anatomical region, the extent of the cancer throughout the body.