DataStar Web

Documents

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Colorectal Cancer Treatment Costs Vary Widely.

Dialog eLinks

Full text available at Roche Link >

Accession number & update

2009102734 20090320.

Source

Gastroenterology, {Gastroenterology}, January 2009, vol. 136, no. 1, p. 6–7, CODEN: GASTA, ISSN: 0016–5085. Publisher: W.B. Saunders, Independence Square West, Philadelphia, PA 19106–3399, USA.

Author(s)

Lang–Les.

Publication year

2009.

Publication date

20090100.

Clinical use of anti–vascular endothelial growth factor monoclonal antibodies in metastatic colorectal cancer.

Dialog eLinks

Full text available at Roche Link >

Accession number & update

18980549 Medline 20090204.

Source

Pharmacotherapy, {Pharmacotherapy}, Nov 2008, vol. 28, no. 11 Pt 2, p. 23S–30S, 49 refs, ISSN: 0277–0008.

Author(s)

Chase–Judy–L.

Abstract

Abstract Vascular endothelial growth factor (VEGF) is the most potent proangiogenic factor and has been identified as an important target of cancer therapy. Blocking endothelial cell VEGF activity inhibits tumor angiogenesis; normalizes tumor vasculature, facilitating improved chemotherapy delivery; and prevents the recruitment of progenitor cells from the bone marrow. **Bevacizumab,** the only United States Food and Drug Administration (FDA)–approved anti–VEGF agent, is a monoclonal antibody that inhibits the binding of VEGF to VEGF receptors. The addition of **bevacizumab** to standard first– and second– line chemotherapy regimens for the treatment of metastatic colorectal cancer improves overall and progression–free survival times and increases the time to disease progression. Studies are evaluating **bevacizumab** as adjuvant therapy. The optimal **bevacizumab** dosage is unknown, but 5 mg/kg every 2 weeks is currently recommended for initial therapy. A surrogate efficacy marker is needed to optimize **bevacizumab** use, both for dose and patient selection; the clinical applicability of several surrogate efficacy markers is being evaluated. Generally, **bevacizumab** is well tolerated; however, several serious adverse effects that may occur (e.g., hypertensive crisis) can usually be appropriately prevented or managed. Although current recommendations suggest the administration of the first **bevacizumab** dose over 90 minutes to prevent infusion–related hypersensitivity reactions, recent study results show that 5 and 10 mg/kg can safely be administered over 10 and 20 minutes, respectively. Whether the addition of **bevacizumab** to metastatic colorectal cancer treatment regimens is a cost–effective treatment option is unknown; health **economic** studies are needed. When used for FDA–approved indications or for off–label indications being evaluated in select clinical trials, Medicare reimburses for **bevacizumab** therapy.

Publication year

2008.

Publication date

20081100.

The cost burden of trastuzumab and bevacizumab therapy for solid tumours in Canada.

Dialog eLinks

Full text available at Roche Link >

Accession number & update

2008496049 20081001.

Source

Current Oncology, {Curr−Oncol}, 2008, vol. 15, no. 3, p. 21−27, 37 refs, CODEN: CUONF, ISSN: 1198−0052. Publisher: Multimed Inc., 66 Martin Street, Milton, ONT L9T 2R2, Canada.

Author(s)

Drucker−Arik, Skedgel−C, Virik−K, Rayson−D, Sellon−M, Younis−T.

Abstract

Objective: Monoclonal antibodies (MAbs) such as trastuzumab and **bevacizumab** have become important yet expensive components of systemic cancer therapy across a variety of disease sites. We assessed the potential cost implications of adopting trastuzumab and **bevacizumab** therapy in the context of their potential utilization in breast, lung, and colorectal cancers. Design: We first estimated MAb costs per patient and treatment indication and then included the MAb acquisition cost and the costs of medical resource utilizations required for therapy delivery. Drug costs were based on 2005 average Canadian wholesale prices, assuming full drug delivery and uncomplicated cycles. A direct−payer perspective was undertaken, and results are reported in Canadian dollars. Potential lifetime costs were then derived according to constructed schema, which account for absolute numbers of target patients and systemic therapy utilization. We subsequently estimated costs of MAb therapy relative to total costs of conventional management without MAb therapy. Results: Trastuzumab costs $49,915 and $28,350 per patient treated in the adjuvant and metastatic breast cancer settings, respectively; **bevacizumab** costs $48,490 and $39,614 per patient treated in the metastatic lung and colorectal cancer settings, respectively. Potential lifetime absolute costs to Canada's health care system were approximately $127 million and $299 million for trastuzumab and **bevacizumab** respectively, corresponding to an average increase in health care expenditure of approximately 19% for breast cancer and 21 % for lung and colorectal cancer over conventional management without MAbs. Conclusions: Novel Mab−based therapies such as trastuzumab and **bevacizumab** will likely add a significant cost burden to Canada's publicly funded health care system. Copyright © 2008 Multimed Inc.

Publication year

2008.

Publication date

20080000.

Bevacizumab: A review of its use in metastatic colorectal cancer.

Dialog eLinks

Full text available at Roche Link >

Accession number & update

2008116266 20080601.

Source

Drugs, {Drugs}, 2008, vol. 68, no. 4, p. 487−506, 64 refs, CODEN: DRUGA, ISSN: 0012−6667. Publisher: Adis International Ltd, 41 Centorian Drive, Private Bag 65901, Mairangi Bay, Auckland 10, 1311, New

Zealand.

Author(s)

McCormack−Paul−L, Keam−Susan−J.

Abstract

Bevacizumab (Avastin®) is a recombinant, humanized monoclonal antibody against vascular endothelial growth factor (VEGF) that is used to inhibit VEGF function in vascular endothelial cells and thereby inhibit tumour angiogenesis, upon which solid tumours depend for growth and metastasis. The addition of **bevacizumab** to fluoropyrimidine−based chemotherapy, with or without irinotecan or oxaliplatin, in both the first− and second−line treatment of metastatic colorectal cancer, significantly increased median progression−free survival or time to disease progression in most randomized controlled trials. **Bevacizumab** was generally, but not always, associated with a survival advantage; in phase III trials, the increases in median overall survival attributable to **bevacizumab** were 4.7 months with first−line therapy and 2.1 months with second−line therapy. In some studies, patients experienced clinical improvement without an apparent overall survival benefit. **Bevacizumab** had acceptable tolerability, with the majority of adverse events being generally mild and clinically manageable. However, from the UK National Health Service perspective, **bevacizumab** was not considered to be cost effective in combination with bolus fluorouracil/folinic acid or irinotecan/bolus fluorouracil/folinic acid. Additional pharmacoeconomic analyses from different perspectives and using clinical data for combinations with the more efficacious infusional fluorouracil/folinic acid plus oxaliplatin or irinotecan chemotherapy regimens are required. Although cost effectiveness may be a concern, the combination of **bevacizumab** and fluoropyrimidine−based chemotherapy has potential in the treatment of metastatic colorectal cancer.

Publication year

2008.

Publication date

20080000.

Cost−effectiveness analysis of bevacizumab combined with chemotherapy for the treatment of metastatic colorectal cancer in Japan.

Dialog eLinks

Full text available at Roche *Link* >

Accession number & update

18042483 Medline 20071101.

Source

Clinical therapeutics, {Clin−Ther}, Oct 2007, vol. 29, no. 10, p. 2256−67, ISSN: 0149−2918.

Author(s)

Shiroiwa−Takeru, Fukuda−Takashi, Tsutani−Kiichiro.

Abstract

BACKGROUND: Rapid progress has been made in the treatment of metastatic colorectal cancer (mCRC). New treatment regimens for mCRC include not only cytotoxic chemotherapy but also targeted monoclonal antibodies, including **bevacizumab.** However, **bevacizumab** is an expensive medication, which costs from 300,000 yen to 400,000 yen (US $2500−$3300) per month. OBJECTIVE: The purpose of this cost− effectiveness analysis was to examine the **economic** efficiency of treating mCRC with **bevacizumab** plus chemotherapy versus chemotherapy alone in Japan. METHODS: We searched an electronic database (MEDLINE, UpToDate, and American Society of Clinical Oncology (ASCO) Virtual Meeting; key terms: **bevacizumab** limited to randomized controlled trial; years: 2000 to present (June 29, 2007)) to detect randomized controlled trials (RCTs) that compared chemotherapy alone with chemotherapy plus **bevacizumab.** To analyze the cost−effectiveness of **bevacizumab,** we used the Weibull regression model and determined an expected treatment duration at each state using reported survival curves of RCTs. We included only the direct medical costs (2006) of these medications to estimate the expected values of incremental costs; thus, the analysis was conducted from the perspective

of the health care payer. The incremental cost−effectiveness ratios (ICERs) were calculated from these expected values of incremental life−years and incremental costs. RESULTS: We identified 5 articles using MEDLINE and 1 trial found on UpToDate and ASCO Virtual Meeting; these data composed the final analysis group. First−line chemotherapy regimens included in this analysis were **bevacizumab** + 5−fluorouracil/leucovorin (FU/LV), irinotecan/FU/LV (IFL), infusional FU/LV/ oxaliplatin (FOLFOX6), bolus FU/LV/oxaliplatin (bFOL), and capecitabine /oxaliplatin (CAPOX). The only second−line chemotherapy regimen included was FOLFOX4. The ICERs of additional **bevacizumab** when combined with FU/LV, IFL, FOLFOX6, bFOL, and CAPOX were 17.4 million yen (US $145,000), 11.9 million yen ($99,000), 13.5 million yen ($113,000), 16.9 million yen ($141,000), and 8.5 million yen ($71,000) , respectively, per life−year gained; the ICER was 14.1 million yen ($118,000) with second−line FOLFOX4. CONCLUSIONS: In this cost− effectiveness analysis in Japan, the ICERs of **bevacizumab** + FU/LV combination treatment, IFL, and second−line FOLFOX4 were high compared with other chemotherapies for mCRC. It remains difficult to assess first−line therapies comprising **bevacizumab** with oxaliplatin−based regimens, especially CAPOX. Further information is needed to assess cost−effectiveness.

Publication year

2007.

Publication date

20071000.

Advances in chemotherapy against advanced or metastatic colorectal cancer.

Dialog eLinks

Full text available at 

Accession number & update

2008204013 20080501.

Source

Digestion, {Digestion}, January 2008, vol. 77, no. SUPPL. 1, p. 13−22, 35 refs, CODEN: DIGEB, ISSN: 0012−2823. Publisher: S. Karger AG, Allschwilerstrasse 10, P.O. Box, Basel, CH−4009, Switzerland.

Author(s)

Omura−Kenji.

Abstract

In the early 1990s, some prospective controlled trials revealed the superiority of chemotherapy for survival compared with best supportive care for advanced or metastatic colorectal carcinoma. Until recently, 5−fluorouracil (5−FU) and leucovorin (LV) were the standard therapies against advanced or metastatic colorectal cancer. Theoretically, LV should increase the antitumor activity of 5−FU, although this effect of LV addition has been controversial. A meta−analysis which analyzed 21 randomized controlled trials revealed that a combination of 5−FU and LV doubled the response rate compared with 5−FU alone (from 11 to 21%) and prolonged the median survival time by about 1 month (from 10.5 to 11.7 months). Chemotherapy against advanced or metastatic colorectal cancer has steadily advanced after the introduction of triplet regimens containing 7−ethyl−10−(4−(1−piperidino)−1−piperidino) carbonyloxy−camptothecin (CPT−11) and (trans−R, R−1,2−diamine cyclohexane)oxalatoplatinum(II) (L−OHP). For LV/5−FU/CPT−11, the regimen in which 5−FU is administered with continuous infusion (FOLFIRI) is preferred compared with the 5−FU bolus infusion. According to the results of the randomized controlled trial comparing FOLFIRI followed by FOLFOX6 and the reverse sequence, FOLFOX6 followed by FOFIRI, in the treatment of advanced colorectal cancer, FOLFIRI and FOLFOX are now considered to have almost the same efficacy in the treatment of advanced or metastatic colorectal cancer. FOLFIRI followed by FOLFOX or FOLFOX followed by FOLFIRI provide a median survival time of about 21 months in advanced or metastatic colorectal cancer. Both an anti−vascular endothelial growth factor monoclonal antibody, **bevacizumab,** and an anti− epidermal growth factor receptor monoclonal antibody, cetuximab, should prolong the survival of advanced or metastatic colorectal cancer by 2−3 months in combination with FOLFIRI or FOLFOX. However, from the viewpoint

of medical **economics,** because of the high acquisition costs in relation to clinical benefits, antibodies are unlikely to represent a cost–utility solution. New agents, including macromolecule agents, small–molecule agents and vaccines, will be introduced alongside chemotherapy against colorectal cancer. Subsequently, clinical researchers will have to consider the cost–utility of these agents. Copyright © 2008 S. Karger AG.

Publication year

2008.

Publication date

20080100.

The cost–effectiveness of bevacizumab in the first–line treatment of metastatic colorectal cancer in England and Wales.

Dialog eLinks

Full text available at Roche Link >

Accession number & update

2007549933 20071101.

Source

European Journal of Cancer, {Eur–J–Cancer}, November 2007, vol. 43, no. 17, p. 2487–2494, 21 refs, CODEN: EJCAE, ISSN: 0959–8049. Publisher: Elsevier Ltd, Langford Lane, Kidlington, Oxford, OX5 1GB, UK.

Author(s)

Tappenden–P, Jones–R, Paisley–S, Carroll–C.

Abstract

Background: **Bevacizumab** is a humanised monoclonal antibody, which has demonstrated significant activity in metastatic colorectal cancer. The aim of this study is to estimate the cost–effectiveness of adding **bevacizumab** to chemotherapy for patients with untreated metastatic colorectal cancer. Methods: A decision–analytic model was developed to estimate the lifetime costs and benefits of adding **bevacizumab** to irinotecan plus FU/LV (IFL) or 5–FU/LV alone. Effectiveness outcomes, health utilities and resource use data were derived from recent **bevacizumab** RCTs and from the literature. Results: Adding **bevacizumab** to IFL costs approximately œ62,857 per QALY gained. Adding **bevacizumab** to 5–FU/LV costs approximately œ88,436 per QALY gained. The acquisition cost of **bevacizumab** is a key determinant of its cost– effectiveness. The probability that **bevacizumab** has a cost– effectiveness ratio that is better than œ30,000 per QALY gained is close to zero. Conclusions: Given high acquisition costs in relation to clinical benefits, **bevacizumab** is unlikely to represent a cost– effective use of NHS resources. © 2007 Elsevier Ltd. All rights reserved.

Publication year

2007.

Publication date

20071100.

Systematic review and economic evaluation of bevacizumab and cetuximab for the treatment of metastatic colorectal cancer.

Dialog eLinks

Full text available at Roche Link >

Accession number & update

2007383763 20070901.

Source

Health Technology Assessment, {Health−Technol−Assess}, March 2007, vol. 11, no. 12, p. iii−103, 162 refs, CODEN: HTASF, ISSN: 1366−5278. Publisher: National Co−ordinating Centre for HTA, Bouldrewood, Mail Point 728, Highfield, Southhampton, UK.

Author(s)

Tappenden−P, Jones−R, Paisley−S, Carroll−C.

Abstract

Objectives: To assess the clinical effectiveness and cost− effectiveness of **bevacizumab** and cetuximab in the treatment of individuals with metastatic colorectal cancer (CRC). Data sources: Searches of main electronic databases were conducted in April and May 2005. Review methods: For the assessment of **bevacizumab,** trials were included if they recruited participants with untreated metastatic CRC for first−line treatment. Only trials comparing **bevacizumab** in combination with irinotecan and/or established fluorouracil (5−FU)− containing or releasing regimens given as first−line therapy were included. For the assessment of cetuximab, trials were included if they recruited participants with epidermal growth−factor receptor− expressing metastatic CRC who had previously failed irinotecan− including therapy. Independent cost−effectiveness models of **bevacizumab** and cetuximab were developed using survival modelling methods. Results: Adding **bevacizumab** to irinotecan in combination with 5−FU/folic acid (FA) plus irinotecan resulted in a statistically significant increase in median overall survival (OS) of 4.7 months. Adding **bevacizumab** to 5−FU/FA resulted in a non−significant increase in median OS of 3.7 months within one study and 7.7 months in another. Adding **bevacizumab** to irinotecan, fluorouracil and leucovorin (IFL) resulted in a statistically significant increase in median progression−free survival (PFS) of 4.4 months. Adding **bevacizumab** to 5−FU/FA resulted in a statistically significant increase in median PFS of 3.7 months, and a statistically significant increase in time to disease progression of 3.8 months compared to FU/FA alone. An overall tumour response rate of 44.8% was reported for **bevacizumab** plus IFL compared to 34.8% for IFL plus placebo. This addition was statistically significant. The addition of **bevacizumab** to 5−FU/FA resulted in a significant difference in tumour response rate within one study, but not another. **Bevacizumab** in combination with IFL or 5− FU/FA was observed to result in an increase of grade 3/4 adverse events. The independent health **economic** assessment suggests that the cost−effectiveness of **bevacizumab** plus IFL is unlikely to be better than œ46,853 per life−year gained (LYG); the cost−utility of **bevacizumab** plus IFL is unlikely to be better than œ62,857 per quality−adjusted life−year (QALY) gained. The cost−effectiveness of **bevacizumab** plus 5−FU/FA versus 5−FU/FA is unlikely to be better than œ84,607 per LYG; the cost−utility of **bevacizumab** plus 5−FU/FA versus 5−FU/FA is unlikely to be better than œ88,658 per QALY gained. A Phase II trial reported a median OS duration of 8.6 months for patients receiving cetuximab plus irinotecan, plus a median time to progression of 4.1 months, a tumour response rate of 22.9% and suggested that treatment with cetuximab in combination with irinotecan is associated with significantly more adverse events (any grade 3 or grade 4 adverse event) than cetuximab monotherapy. The single arm study of cetuximab plus irinotecan reported a median OS duration of 8.4 months, a median time to progression of 2.9 months and a tumour response rate of 15.2%. The cost−effectiveness model suggested that the expected survival duration of patients receiving cetuximab plus irinotecan is 0.79 years (9.5 months) when the proposed continuation rule is applied. In order for cetuximab plus irinotecan to achieve a cost−utility ratio of œ30,000 per QALY gained, treatment with cetuximab plus irinotecan must provide an additional 0.65 life years (7.8 months) over treatment with active/best supportive care, implying that survival in the active/best supportive care group must be 0.14 life years (1.7 months) or less. Conclusions: The trials indicate that **bevacizumab** in combination with 5−FU/FA, and **bevacizumab** in combination with IFL, is clinically effective in comparison to standard chemotherapy options for the first−line treatment of metastatic CRC. The health **economic** analysis suggests that the marginal cost−utility of **bevacizumab** plus IFL versus IFL is unlikely to be better than œ62,857 per QALY gained, and the marginal cost−utility of **bevacizumab** plus 5−FU/FA versus 5−FU/FA is unlikely to be better than œ88,658 per QALY gained. There is no direct evidence to demonstrate whether cetuximab in combination with irinotecan improves health−related quality of life or OS in comparison to active/best supportive care or oxaliplatin plus 5−FU/FA, although the evidence on tumour response rates suggests that cetuximab plus irinotecan has some clinical activity. While it is difficult to surest whether cetuximab represents value for money, indirect comparisons suggest that the incremental cost−utility of cetuximab plus irinotecan is unlikely, to be better than œ30,000 per QALY gained. This review highlights a number of areas for further research, including clarifying the true impact of, first−line **bevacizumab** in combination with irinotecan and/or infusional

5−FU/FA, without subsequent **bevacizumab** treatment following disease progression, on OS in patients with metastatic CRC who are representative of the typical population of CRC patients in England and Wales. Further research concerning the impact of therapies on health−related quality of life is essential. © Queen's Printer and Controller of HMSO 2007. All rights reserved.

Publication year

2007.

Publication date

20070300.

Genentech caps cost of cancer drug for some patients.

Dialog eLinks

Full text available at Roche Link >

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17061339 Medline 20061001.

Source

The New York times, {NY−Times−Print}, 12 Oct 2006, p. C2, ISSN: 0362−4331.

Author(s)

Pollack−Andrew.

Abstract

General note: KIE Bib: health **care**/economics; patient care/drugs.

Publication year

2006.

Publication date

20061012.

Bevacizumab and cetuximab for colorectal cancer.

Dialog eLinks

Full text available at Roche Link >

Accession number & update

2006243169 20060101.

Source

Drug and Therapeutics Bulletin, {Drug−Ther−Bull}, May 2006, vol. 44, no. 5, p. 37−40, 29 refs, CODEN: DRTBA, ISSN: 0012−6543.

Abstract

Every year in the UK, around 16,000 people die from colorectal cancer, the second commonest cause of death from cancer in the UK after lung cancer. Over half of all people with colorectal cancer eventually die of metastatic disease. While median survival has increased with optimal use of combination chemotherapy, only a small minority of patients are still alive 5 years after diagnosis of metastases. **Bevacizumab** (pronounced be−va−see−zoo−mab) (Avastin − Roche) and cetuximab (se−tuks−ee−mab) (Erbitux− Merck) are two new monoclonal antibodies licensed for treating patients with metastatic colorectal cancer. Here we assess their efficacy and safety.

Publication year

2006.

Publication date

20060500.

Appraisal of bevacizumab and cetuximab for treatment of metastatic colorectal cancer in the UK.

Dialog eLinks

Full text available at Roche Link >

Accession number & update

17039634 Medline R 20061001.

Source

The lancet oncology, {Lancet−Oncol}, Oct 2006, vol. 7, no. 10, p. 807−8, ISSN: 1470−2045.

Author(s)

Barnett−David, Stevens−Andrew, Longson−Carole.

Publication year

2006.

Publication date

20061000.

Targeted therapy in colorectal cancer.

Dialog eLinks

Full text available at Roche Link >

Accession number & update

16728921 Medline 20060501.

Source

Clinical advances in hematology & oncology : H&O, {Clin−Adv−Hematol− Oncol}, Feb 2006, vol. 4, no. 2, p. 124−32, 62 refs, ISSN: 1543−0790.

Author(s)

Rajpal−Supriya, Venook−Alan−P.

Abstract

Advances in chemotherapeutic agents have led to improved outcomes for patients with metastatic colorectal cancer (CRC). Chemotherapies, however, are limited by their toxicities and lack of specificity. Aberrations in the regulation and expression of growth factors have been implicated in the development of CRC, and this understanding has led to the development of targeted agents. In 2004, two novel agents, **bevacizumab** and cetuximab, were approved by the US Food and Drug Administration for the treatment of metastatic CRC. **Bevacizumab,** a humanized monoclonal antibody to vascular endothelial growth factor, and cetuximab, a human−mouse chimeric monoclonal antibody to the epidermal growth factor receptor, have changed the field dramatically. **Bevacizumab** appears to augment the efficacy of combination chemotherapy regimens for the treatment of metastatic CRC in both the first− and second−line settings, and the role of **bevacizumab** as part of adjuvant treatment is the subject of ongoing trials. However, because of the increased incidence of serious arterial thromboembolic events, gastrointestinal perforations, bleeding complications, and hypertension associated with **bevacizumab,** this agent is probably not indicated in all circumstances. Combination treatment with cetuximab and irinotecan appears appropriate in patients with advanced CRC who have failed irinotecan. Patients who are unable to receive additional irinotecan may be treated with cetuximab monotherapy. Positive epidermal growth factor receptor status by immunohistochemistry of a tumor specimen is presently mandated to determine candidacy for this therapy, although this assay appears to be suboptimal and newer assessment techniques to determine suitability for therapy must be developed. Phase III trials should shed light on the role of cetuximab in the first−line metastatic and adjuvant settings. Multitargeted strategies in CRC combining chemotherapy with **bevacizumab** and cetuximab are currently being explored. Further advances in the treatment of CRC are expected through continued scientific investigation and well−designed clinical trials.

Publication year
2006.
Publication date
20060200.

Bevacizumab for advanced colorectal cancer.

Dialog eLinks
Full text available at Roche Link >
Accession number & update
15612152 Medline R 20040101.
Source
Issues in emerging health technologies, {Issues−Emerg−Health−Technol}, Dec 2004, no. 63, p. 1−4, ISSN: 1488−6324.
Author(s)
Hadj−Tahar−A.
Abstract
Bevacizumab is a recombinant humanized monoclonal antibody that targets vascular endothelial growth factor (VEGF). It is thought that **bevacizumab** inhibits the formation of new blood vessels. Two clinical trials show that the addition of **bevacizumab** to a regimen of either fluorouracil plus leucovorin (FL) or FL combined with irinotecan (IFL) , significantly improves response rate and time to tumour progression and increases overall survival for patients with advanced colorectal cancer (ACC). Thromboembolic events are the most clinically significant adverse events, but hypertension, hemorrhage and gastrointestinal perforation are other potential safety concerns. More studies are needed to compare the combination of **bevacizumab** plus IFL to other chemotherapy regimens used in the treatment of ACC. The addition of **bevacizumab** to 5−fluorouracil−based chemotherapy regimens will significantly increase the costs of palliation for ACC.
Publication year
2004.
Publication date
20041200.

Bevacizumab in colorectal cancer.

Dialog eLinks
Full text available at Roche Link >
Accession number & update
15490497 Medline R 20040101.
Source
The New England journal of medicine, {N−Engl−J−Med}, 14 Oct 2004, vol. 351, no. 16, p. 1690−1; author reply 1690−1, ISSN: 1533−4406.
Author(s)
Sharieff−Waseem.
Publication year
2004.
Publication date
20041014.

Two steps forward in the treatment of colorectal cancer.

Dialog eLinks

Full text available at Roche Link >

Accession number & update

15175443 Medline R 20040101.

Source

The New England journal of medicine, {N–Engl–J–Med}, 3 Jun 2004, vol. 350, no. 23, p. 2406–8, ISSN: 1533–4406.

Author(s)

Mayer–Robert–J.

Publication year

2004.

Publication date

20040603.

Search Strategy

No.	Database	Search term	Info added since	Results
1	EMYY	monoclonal ADJ antibodies	unrestricted	105553
2	EMYY	ANTIBODIES–MONOCLONAL.MJ.	unrestricted	0
3	EMYY	2 AND bevacizumab	unrestricted	0
4	EMYY	colorectal ADJ cancer	unrestricted	40701
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35	EMYY	26 AND 28 AND (30 OR 32 OR 34) AND LG=EN AND HUMAN=YES	unrestricted	0
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		fees OR charges OR price OR pricing OR pharmacoeconomics OR budget OR expenditure OR qaly OR health ADJ technology ADJ appraisal).TI.		
37	EMYY	26 AND 28 AND 36 AND LG=EN AND HUMAN=YES	unrestricted	0
38	MEYY	monoclonal ADJ antibodies	unrestricted	81516
39	MEYY	ANTIBODIES–MONOCLONAL.MJ.	unrestricted	35350
40	MEYY	39 AND bevacizumab	unrestricted	1269
41	MEYY	colorectal ADJ cancer	unrestricted	31236
42	MEYY	COLORECTAL–NEOPLASMS.MJ.	unrestricted	27636
43	MEYY	cost	unrestricted	209232
44	MEYY	COST–OF–ILLNESS.DE. OR HEALTH–CARE–COSTS.DE. OR ECONOMICS–HOSPITAL.DE.	unrestricted	28907
45	MEYY	economic	unrestricted	256233
46	MEYY	ECONOMICS.W..DE. OR BUDGETS.W..DE. OR COST–SAVINGS.DE.	unrestricted	199721
47	MEYY	health ADJ technology ADJ appraisal	unrestricted	6
48	MEYY	TECHNOLOGY–ASSESSMENT–BIOMEDICAL.DE. OR QUALITY–ADJUSTED–LIFE–YEARS.DE.	unrestricted	8616
49	MEYY	40 AND 42 AND (44 OR 46 OR 48) AND LG=EN AND HUMAN=YES	unrestricted	11
50	MEYY	(economics OR costs OR cost ADJ analysis OR cost ADJ of ADJ illness OR healthcare ADJ costs OR economic ADJ value ADJ of ADJ life OR fees OR charges OR price OR pricing OR pharmacoeconomics OR budget OR expenditure OR qaly OR health ADJ technology ADJ appraisal).TI.	unrestricted	65963
51	MEYY	40 AND 42 AND 50 AND LG=EN AND HUMAN=YES	unrestricted	4
52	EMYY MEYY	combined sets 21, 49	unrestricted	18
53	EMYY MEYY	dropped duplicates from 52	unrestricted	3
54	EMYY MEYY	unique records from 52	unrestricted	15

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