Topotecan, pegylated liposomal doxorubicin hydrochloride, paclitaxel, trabectedin and gemcitabine for advanced recurrent disease only (Review of TA 91 & TA 222)

ERRATUM

This report was commissioned by the NIHR HTA Programme as project number 10/108

BMJ Technology Assessment Group

The table below lists the page to be replaced in the original document and the nature of the change:

Page No.	**Change**
Page 152, paragraph 2	Paragraph 2 starting “not to differ”. This paragraph is extraneous (discusses OS) and the text has been deleted.
Page 361, paragraph 3	Paragraph 3 text from "This is because" to "may no longer reflect clinical practice", duplicates text before it and has been deleted.

(<5 cm or ≥5 cm). The analysis found that (monotherapy vs combination therapy) was not predictive of PFS. However, PFI and ECOG PS were identified as independent predictors of PFS, with p values of 0.03 and 0.01, respectively.

Topotecan administered on 5 consecutive days (conventional regimen) versus topotecan administered weekly

PFS was evaluated as a secondary outcome by Sehouli *et al*.[23] A definition for PFS was not provided in the full publication. There was no statistically significant difference between treatments in PFS (HR 1.29, 95% CI: 0.96 to 1.76; p = 0.088). Median PFS was 3.0 months with conventional topotecan compared with 4.4 months with weekly topotecan.

maintenance with oral etoposide, was estimated to be the cheapest treatment option (£8,194), followed by best supportive care (£12,622). The TAG considers that the cost associated with best supportive care may have been overestimated. The palliative cost associated with ovarian cancer was estimated by Guest *et al.* to be £4,789 (at 2000/2001 prices) for an average time period of 399 days.[114] This cost predominantly consisted of hospitalisation costs (71% of costs). Updating the estimate of palliative care for ovarian cancer patients from Guest *et al*. to current prices using the Hospital & Community Health Services index results in a cost of £6,963;[112] equating to £531 per month. This cost is applied monthly to all platinum resistant/refractory patients following entry into the progressed disease health state, and all platinum sensitive patients following six months of residence in the progressed disease health state.

The TAG notes that the analysis carried out by Guest *et al*. has several weaknesses. In particular, ovarian cancer estimates are based upon a small sample size (n=21) and does not consider costs for patients not requiring a strong opioid. In addition, the analysis was carried out in 2000/2001 and may no longer reflect clinical practice. To establish the impact of this uncertainty, the TAG varied this cost in sensitivity analysis for the base case; however, the TAG considers that future research into the cost of best supportive care for women with ovarian cancer may be warranted (Section 8.1).

5.2.14 Summary of the Technology Assessment Group *de novo* economic evaluation

Following review of the economic literature and manufacturer submissions, the TAG developed a *de novo* economic model to address the decision problem outlined for this MTA. The economic model was based upon the model structure for TA91 in which three health states were modelled; stable disease, progressed disease and death. Within the TA91 model, the proportions of patients within each health state were calculated from estimates of mean time to progression and mean time to death, available from the literature. Utilities and costs were then applied to mean estimates of time spent within each health state. The ERG responsible for appraisal of a subsequent STA (TA222) in which the same model structure was applied, commented that the use of mean estimates resulted in difficulties in the application of discounting; this is because the proportion of patients in each health state over time is not explicitly modelled. Therefore, in order to address this concern, the model used in TAG analyses incorporates monthly estimates of PFS and OS over time (Section 5.2.7).