Treatment of advanced renal cell carcinoma in Spain: oncologists' preferences

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PRESENTED AT:

INTRODUCTION

Several systemic therapy options are available for advanced renal cell carcinoma (aRCC).(1) Preference for a drug depends not only on the efficacy but as well on other attributes, such as adverse events and the administration method. Thus, it can be expected that the preferences of health care professionals would have an impact on the successful treatment of disease.(2)

The objetive of the study was to determine oncologists' preferences for the characteristics of aRCC treatment in Spain.

METHODS

• Observational study based on a discrete choice experiment (DCE), developed in four phases (**Figure 1**).
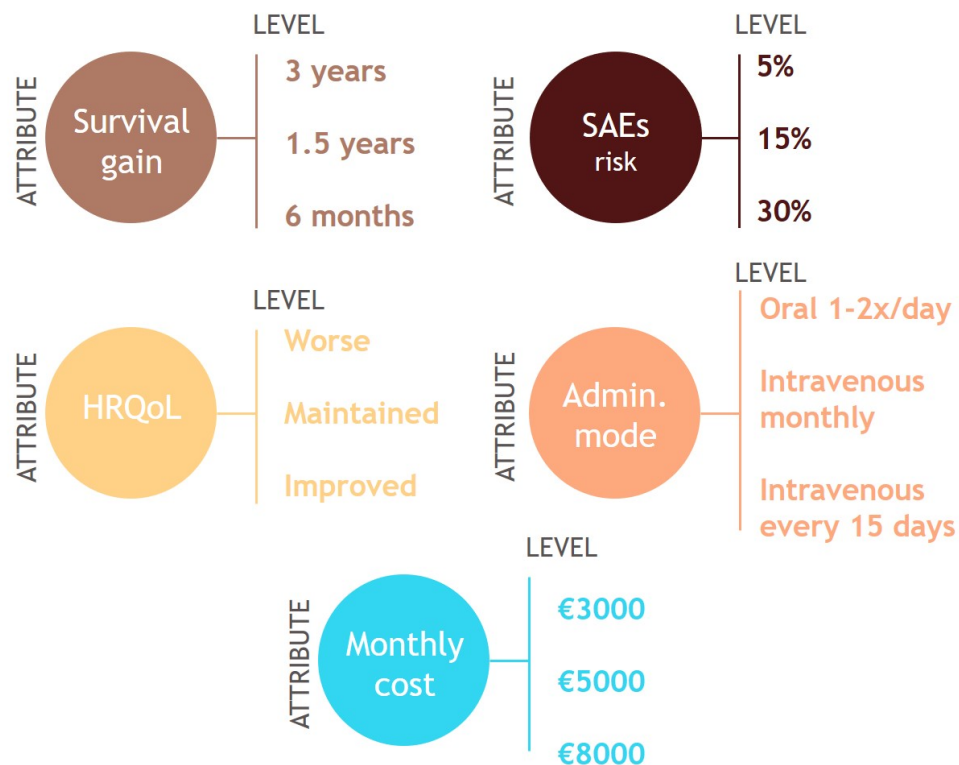
Figure 1. Study phases
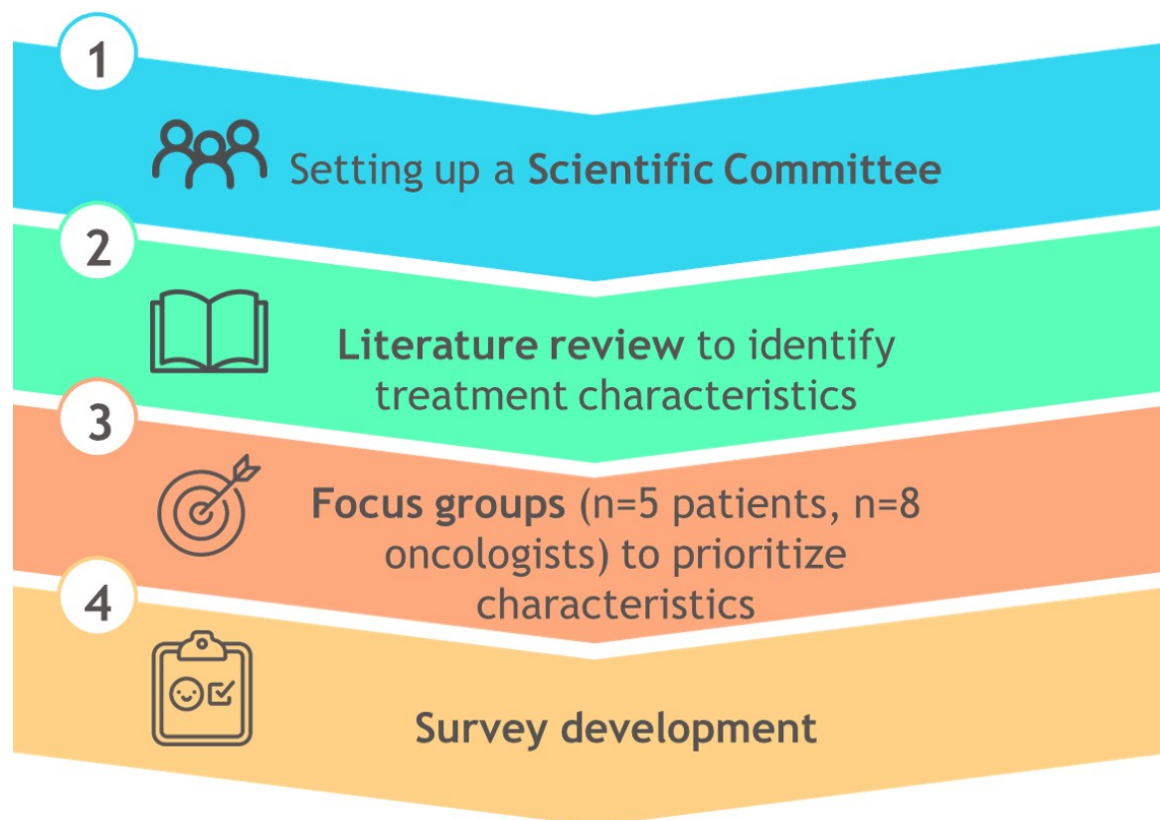
• Five treatment attributes, with three levels each, were included in the DCE (**Figure 2**).

Figure 2. Attributes and levels included in the DCE

HRQoL: Health-related quality of life; SAEs: Severe adverse events; Admin.: Administration

• A fractional factorial analysis (orthogonal matrix) produced 18 scenarios, that were divided into 2 blocks of 9 sets of choices and presented in a survey.

• Data were analyzed using a mixed logit model. Relative importance of attributes was calculated. Additionally, willingness to pay (WTP) for the treatment (cost assumed by the health system) and maximum acceptable risk (MAR) of SAEs in exchange for clinical efficacy were estimated from the DCE.

RESULTS

67 Oncologists participated in the study

52.2% men

Mean age **41.9** years [standard deviation: 8.4]
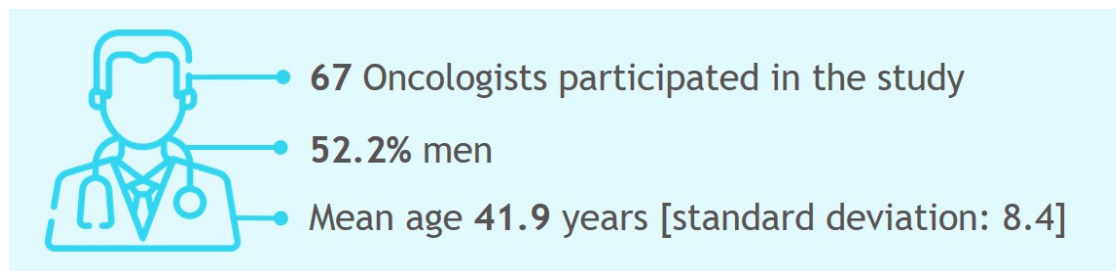
• All attributes/levels were significant predictors of treatment choice (P < 0.05), except for monthly intravenous administration and HRQoL maintenance (**Figure 3**).

Figure 3. Partial utilities (partial preferences)
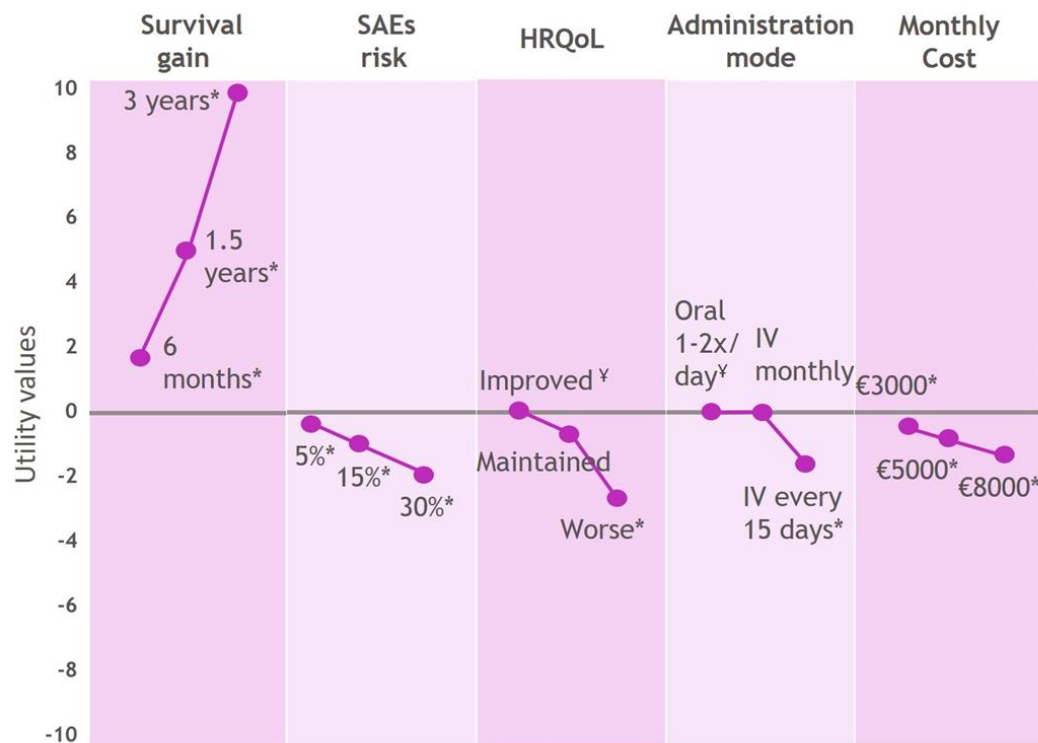
IV: intravenous; HRQoL: Health-related quality of life; SAEs: Severe adverse events
The coefficients from the mixed logit model indicate the partial utility value corresponding to each level of each attribute, using a reference level. Attributes with quantitative levels (survival gain, SAEs risk and cost) were transformed into linear variables. The utility value per unit was obtained.
The higher the partial utility value, the greater the preference for the level within the attribute.
¥ Reference level; *P < 0.05: significant predictor of treatment choice

• The highest relative importance was attributed to survival gain (54.7%), followed by HRQoL (18.0%), administration mode (11.1%), SAEs (10.8%), and treatment cost (5.5%) (**Figure 4**).

Figure 4. Relative importance of attributes
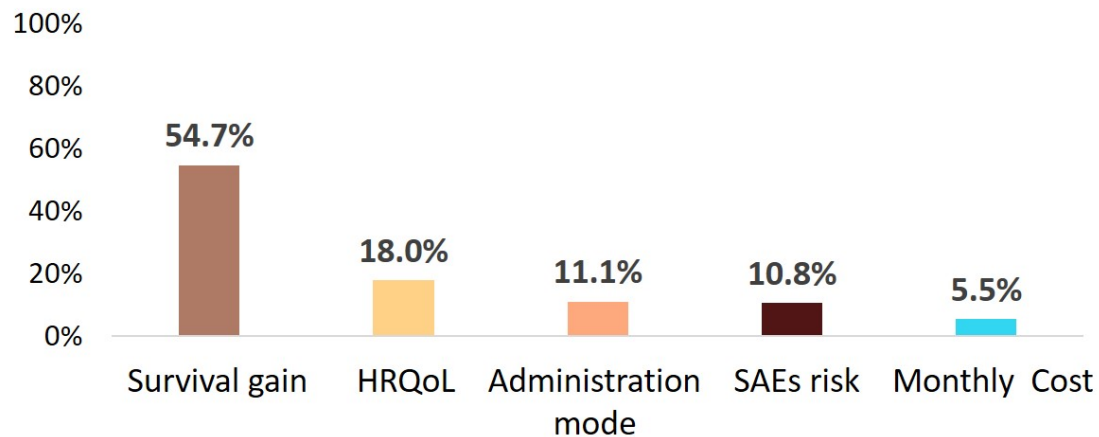
HRQoL: Health-related quality of life; SAEs: Severe adverse events

WTP Higher cost would be accepted for extending survival by 1 month (€1,656.5) than for reducing SAEs risk by 1% (€391.3).

MAR The maximum acceptable risk for extending survival by 1 month was 4.2%.

CONCLUSIONS

From the oncologists' perspective, survival gain is the primary goal of aRCC treatment. HRQoL, administration mode and SAEs are also important attributes to consider for decision-making, while treatment cost has low impact on treatment election.

DISCLOSURES

ACKNOWLEDGEMENTS

- The clinical study team who participated in the study

- The CRO Outcomes'10

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ABSTRACT

Objective

Several systemic therapy options are available for advanced renal cell carcinoma (aRCC) and physicians assess the appropriate regimen for each patient based on treatment characteristics. The aim of the study is to determine oncologists' preferences for the characteristics of aRCC treatment in Spain.

Methods

Observational study based on a discrete choice experiment (DCE), developed in four phases: 1) setting up a scientific committee to lead the project; 2) literature review to identify treatment characteristics; 3) focus groups (5 patients, 8 oncologists) to prioritize characteristics; 4) survey development. Five treatment attributes, with three levels each, were included in the DCE: survival gain (6months, 1.5years, 3years), severe adverse effects (SAEs) (5%, 15%, 30%), health-related quality of life (HRQoL) (worse, maintained, improved), administration mode (oral 1-2/day, intravenous monthly, intravenous every 15 days) and monthly cost (€3000, €5000, €8000). Data were analyzed using a mixed logit model. Relative importance (RI) of attributes was calculated. Additionally, willingness to pay for the treatment (cost assumed by the health system) and maximum acceptable risk (MAR) of SAEs in exchange for clinical efficacy were estimated from the DCE.

Results

Sixty-seven oncologists participated in the study (52.2% men, mean age 41.9 years [standard deviation: 8.4]). All attributes/levels were significant (p<0.05), except for monthly intravenous administration and HRQoL maintenance. The highest RI was attributed to survival gain (54.7%), followed by HRQoL (18.0%), administration mode (11.1%), SAEs (10.8%), and treatment cost (5.5%).

Higher cost would be accepted for extending survival by 1 month than for reducing SAEs risk by 1%. The MAR in exchange for extending survival by 1 month was 4.2%.

Conclusions

From the oncologist's perspective, survival gain is the primary goal of aRCC treatment. HRQoL, administration mode and SAEs are also important attributes to consider for decision-making, while treatment cost has low impact on treatment election.

REFERENCES

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