**PMS13**

### PREVALENCE OF FIBROMYALGIA IN RUSSIA

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**OBJECTIVES:** To assess the estimated prevalence of fibromyalgia syndrome (FM) among the adult population in the general population in Russia, using the London Fibromyalgia Epidemiology Study – Screening Questionnaire (LFESSQ) and American College of Rheumatology (ACR) classification criteria. **METHODS:** The validated Russian version of the LFESSQ was administered to a representative community sample of 1,610 subjects aged over 15 years, selected by the quota method. A positive screen was defined as: (1) meeting the 4-pain criteria alone (LFESSQ-4), or meeting both the 4-pain and 2-fatigue criteria (LFESSQ-6). The questionnaire was submitted to a sample of rheumatology outpatients (n = 399), who were then examined by a trained rheumatologist to confirm or exclude the diagnosis of FM according to the 1990 American College of Rheumatology criteria. The prevalence of FM in the general population was estimated by applying the predictive positive value to eligible community subjects (i.e., positive screens). **RESULTS:** In the community sample, 13.8% screened positive for LFESSQ-6 (18.4% in females and 8.1% in males respectively). Among rheumatology outpatients, 43.6% were screened positive (44.3% in females and 40.5% in males respectively), whereas 6.5% were confirmed FM cases. The prevalence of FM was estimated at 2.1% (95% CI: 1.4%–2.8%, 2.8% in females and 1.2% in males respectively) in the Russian general population. **CONCLUSIONS:** Our findings are in agreement with those of earlier national survey reports. A point prevalence of 2.1% would translate in approximately 2.5 million of patients with FM in Russia.

**PMS14**

### THE RELATIONSHIP BETWEEN SURGICAL DELAY OVER 24 HOURS AND 30 DAYS MORTALITY FOLLOWING FEMORAL NECK FRACTURE IN THE PRESENCE OF DIFFERENT CO-MORBIDITIES

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**OBJECTIVES:** The aim of our study is to analyze the relationship between surgical delay over 24 hours and 30 days mortality following femoral neck fracture in the presence of different co-morbidities in patients aged over 60 years. **METHODS:** Data were derived from the database of the National Health Insurance Fund Administration according to the ICD 10th revision's S7200 code. The study included patients aged over 60 years old discharged from inpatient care institutions following the primary treatment of femoral neck fractures. The patients with polytrauma were excluded from the study. In case of surgical delay six hours mortality was the reference. Data were evaluated according to sex, age, type of fracture, patient turnover of institutions, type of surgery, early complications, hospital type, day of operation. The following co-morbidities were included into the analysis: C00-C97, D60-D64, E10-E16, F00-F99, G20-G26, G80-G83, I10-I15, I20-I25, I30- I52, I60-I69, I70, J00-J22, J40-J47, L89, N30-N39). Statistical analysis has been performed by logistic regression (Odds Ratio(95%CI), p < 0,05). **RESULTS:** Altogether 3783 patients were involved into the study. Surgical delay (24 h+/0–6 h) OR = 1.5009, p = 0.0095. The following co-morbidities (ICD codes with OR and p value) proved to be statistically significant predictors: C00-C97: 2,6381(0.0274), G80-G83: 2.5984(0.0224), I20-I25: 1.6125(0.0438), I30-I52: 2.2758(0.0246), I70: 1.7281(0.0328), J00-J22: 2.2884(0.04), J40-J47: 2.3204(0.0141). **CONCLUSIONS:** Longer than 24 hours surgical delay significantly increased the risk of 30 days mortality compared to 6 hours delay. The longer than 24 hours surgical delay of treatment of elderly femoral neck fracture proved to be statistically significant predictors of 30 days mortality: malignancies, cerebral paralyzed disorders, ischemic and other heart diseases, arteriosclerosis, infections of the upper and lower respiratory system and chronic diseases of the lower respiratory system. In order to decrease the risk of early mortality it is essential strive after earliest surgical treatment with special respect the high risk patient group with co-morbidities.

**PMS15**

### RELATIONSHIP BETWEEN SURGICAL INTERVENTION TYPE AND 30 DAYS MORTALITY OF ELDERLY FEMORAL NECK FRACTURE IN THE PRSENCE OF DIFFERENT CO-MORBIDITIES

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**OBJECTIVES:** The aim of our retrospective study is to analyze the relationship between type of operation and 30 days mortality following femoral neck fracture in the presence of different co-morbidities in patients aged over 60 years. **METHODS:** Data were derived from the database of the National Health Insurance Fund Administration according to the ICD 10th revision's S7200 code. The study included patients aged over 60 years old discharged from inpatient care institutions following the primary treatment of femoral neck fractures. The patients with polytrauma were excluded from the study. Osteosynthesis was compared to arthroplasty as reference surgical method. Data were evaluated according to sex, age, type of fracture, patient turnover of institutions, surgical delay, early complications, hospital type, day of operation. The following co-morbidities were included into the analysis: C00-C97, D60-D64, E10-E16, F00-F99, G20-G26, G80-G83, I10-I15, I20-I25, I30- I52, I60-I69, I70, J00-J22, J40-J47, L89, N30-N39). Statistical analysis has been performed by logistic regression (Odds Ratio[95%CI], p < 0.05). **RESULTS:** Altogether 3783 patients were involved into the study. Type of surgical intervention (osteosynthesis/arthroplasty) OR: 1.7265, p: 0.0128. The following co-morbidities (ICD codes with OR and p value) proved to be statistically significant predictors: I10-I15: 2,0759(0.0136), I60-I69: 2.5104(0.0498), J40-J47: 2.8177(0.0305). **CONCLUSIONS:** Osteosynthesis significantly increased the risk of 30 days mortality compared to arthroplasty. Osteosynthesis treatment of elderly femoral neck fracture proved to be statistically significant predictors of 30 days mortality: cerebrovascular disorders and chronic diseases of the lower respiratory system. A possible explanation of the difference in mortality can be that because of the higher risk of arthroplasty more healthy patients are selected for arthroplasty, while patient with poorer general health status undergo osteosynthesis having lower surgical risk.

**PMS16**

### ESTIMATION OF LIFE EXPECTANCIES AND LOSS OF LIFE EXPECTANCIES FOR WORKERS WITH PERMANENT OCCUPATIONAL DISABILITY OF UPPER AND LOWER LIMBS: A FOLLOW-UP STUDY OF 69,964 WORKERS FOR 21 YEARS

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**OBJECTIVES:** This study intends to estimate the life expectancies and loss of life expectancies for workers with permanent occupational disability of upper and lower limbs in Taiwan. **METHODS:** We collected all cases of permanent occupational disability from the database of compensation claim of Bureau of Labor Insurance between 1986 and 2006, which were linked with the national mortality registry to obtain the survival function. We generated survival curve for age- and sex-matched reference population from the life table of the Taiwan general population in 2000 through Monte Carlo method. Lifetime survival of the workers (up to 1000 months) were obtained using linear extrapolation of a logit-transformed curve of the survival ratio between the workers and reference populations. **RESULTS:** The life loss for workers with leg amputation and injury were 51.5 ± 19.7, and 98.0 ± 16.8 life-months, respectively, while those for workers with arm amputation and injury were 153.9 ± 63.1 and 81.5 ± 29.3, respectively. However, workers with permanent toes and fingers showed no statistically significant loss of life expectancies compared with the general populations. **CONCLUSIONS:** Workers with permanent occupational disability of arm or leg suffered from significant loss of life expectancies, which should be considered for compensation and cost-effectiveness analysis of prevention for these populations.

## MUSCULAR-SKELETAL DISORDERS – Cost Studies

**PMS17**

### NATIONAL COST OF ILLNESS STUDY COMPARING VETERAN PATIENTS WITH GOUT TO THOSE WITH DIFFICULT TO MANAGE GOUT

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**OBJECTIVES:** To measure the health care utilization of US veteran patients with gout and to determine additional costs associated with difficult to manage gout (DMG). **METHODS:** Using diagnostic codes (ICD-9 CD = 274.XX), we identified patients with gout in 2004 from the national Veterans Affairs Health Care System (VA) databases. We then collected all administrative data (demographic, inpatient and outpatient care, pharmacy, laboratory, and tests) for these patients over the years 2004–2006. DMG patients were identified by diagnostic codes associated with complications of the skin (tophi), eye, nerve, and kidney. We created data summaries for each patient by year; including diagnoses, treatments, drug therapies, laboratory tests, and surgeries. **RESULTS:** There were 200,772 patients identified in 2004. Each year, heathcare costs per patient were significantly higher (Kruskal Wallis tests, P < 0.001) for DMG versus other gout patients: inpatient costs in 2006. In addition DMG patients were significantly (P < 0.001), had higher Charlson co-morbidity scores and were more likely to have concomitant cardiovascular, renal, and liver diseases. A limitation of the study is the lack of specificity of diagnostic codes for complications due to gout, which may impact the sample size. **CONCLUSIONS:** Health care costs are significantly higher for DMG patients. We note that increased inpatient plus outpatient costs for DMG patients were $10,000 to $16,000 per patient-year. These VA patients also have significantly more co-morbid conditions than other gout patients.

**PMS18**

### ESTIMATION OF COSTS RELATED TO ADVERSE EVENTS IN NSAID TREATMENT OF OSTEOARTHRITIS – A COMPARISON BETWEEN CELECOXIB AND IBUPROFEN USING A VALIDATED MODEL

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**OBJECTIVES:** To quantify and compare the overall adverse event (AE) related costs and their constituents associated with celecoxib and traditional NSAID treatment in osteoarthritis (OA). **METHODS:** Using an amended version of a recent NICE Markov