zero, and 2-4 concomitant vaccines, respectively. About 49% of the reports indicated that patients were on concurrent medications at the time of vaccination; yet, only 12% of the reports stated that the patients were having coexisting illnesses at vaccination time. Compared to other vaccines, FLU and MQN vaccines showed significantly, higher AEFI values (10.5, 95%CI 9.4-11.8). (4, 95%CI 3.4-6.6).

CONCLUSIONS: It can be postulated that some vaccines are associated with GBS, especially FLU and MQN vaccines; underscore the importance of monitoring patients for postvaccination signs and symptoms of GBS. While healthcare professionals are expected to promote vaccination, they should also continue to report vaccine-associated adverse events to vaccine safety monitoring systems, e.g. VAERS.

PIN2

HEALTH OUTCOMES OF CLINICALLY RELEVANT PATIENT POPULATIONS TREATED WITH DAPTOMYCIN FOR MECHELLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) SKIN INFECTIONS

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OBJECTIVES: MRSA skin infections are associated with high morbidity and cost. Little is known about real-world daptomycin effectiveness in relevant subpopulations. We evaluated outcomes including time to response, duration of antibiotic therapy, and antibiotic-related hospital length of stay (AR-LOS) in subpopulations of patients with MRSA skin infections treated with daptomycin. METHODS: Patients with MRSA skin infections were identified in a retrospective, multicenter, observational cohort study. Clinical data were reviewed describing safety and real-world effectiveness of patients treated with daptomycin (Cubicin Outcomes Registry and Experience, CORE®). Investigators assessed patient outcome at the end of daptomycin therapy. Subpopulations of interest included those with reduced vancomycin susceptibility (MIC ≥2mg/mL), the elderly, diabetics, and those with renal dysfunction. RESULTS: A total of 137 patients were identified: 53% male, 33% <65yo, 31% diabetic, 6% CrCl <30ml/min. Of patients with vancomycin MICs, 14% were ≥2. Median daptomycin dose was 6mg/kg; 82% had prior antibiotics (66% of which was vancomycin). Success occurred in 94% overall, and was 100% in first-line daptomycin, 95% as second line. Time to clinical response ranged from 2-4 days. Care population had a median AR-LOS of 5 days for both first and second-line therapy. Median AR-LOS tended to be greater among subpopulations: those with vancomycin MIC ≥2 [5 vs. 4 days], >65 yr vs [5 vs. 5 days], diabetics [6 vs. 4 days], and those with CrCl <30 vs. 30 vs. 30 days, compared to those without each respective condition. Total treatment duration (inpatient and outpatient) ranged from 3 days, depending on the clinical subgroup. 11/137 patients (8.3%) had AEs possibly related to daptomycin; discontinuation due to AEs was 5.8%.

CONCLUSIONS: This evaluation of relevant patient populations provides meaningful information about real-world effectiveness of daptomycin-treated MRSA skin infections. AR-LOS was longer in evaluated subgroups, particularly those with CrCl <30ml/min. Additional real-world evaluations, including in relevant subpopulations, are warranted to further evaluate relevant outcomes in various subpopulations with MRSA skin infections.

PIN3

A META-ANALYSIS OF EFFICACY AND SAFETY OF LINEZOLID FOR INFECTED DIABETIC FOOT TREATMENT

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OBJECTIVES: In patients with HIV-1, the reduction in RNA copies associated to treatment has shown a better survival rate. The Highly Active Antiretroviral Therapy (HAART) is the recommended treatment for those patients. As a chronic disease, the adherence to treatment and adverse effects plays a major role. The objective of this study is to evaluate the efficacy and safety of the combination Efavirenz, Tenofovir and Emtricitabine (EFV/TDF/FTC) estimated (Staph. aureus/H11002) 0.61 p/H11021 ampicillin/sulbactam (OR 0.40; CI95% 0.27-0.69) vs. piperacillin/tazobactam (OR 0.52; CI95% 0.34-0.77). The 2-4 grade adverse events rates at 48 weeks were for EFV/ TDF/FTC 0.79; for the combination 0.51; for ZDV/TDF/FTC 0.36; ZDV/TDF/FTC 0.29; and for ZDV/TDF/FTC 0.27.

CONCLUSIONS: The combination EFV/TDF/FTC is the most studied combination and is clinically effective at 48 weeks, with good safety profile. The administration once a day improves adherence to treatment.

PIN4

EFFICACY AND SAFETY OF THE COMBINATION EFAVIRENZ (EFV), TENOFOVIR (TDF) AND EMTRICITABINE (FTC) ONCE A DAY IN TREATMENT OF NAÏVE ADULT PATIENTS WITH HIV-1 INFECTION: A SYSTEMATIC REVIEW

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OBJECTIVES: In patients with HIV-1, the reduction in RNA copies associated to treatment has shown a better survival rate. The Highly Active Antiretroviral Therapy (HAART) is the recommended treatment for those patients. As a chronic disease, the adherence to treatment and adverse effects plays a major role. The objective of this study is to evaluate the efficacy and safety of the combination Efavirenz, Tenofovir and Emtricitabine (EFV/TDF/FTC) estimated (Staph. aureus/H11021) 0.61 p/H11021 ampicillin/sulbactam (OR 0.40; CI95% 0.27-0.69) vs. piperacillin/tazobactam (OR 0.52; CI95% 0.34-0.77). The 2-4 grade adverse events rates at 48 weeks were for EFV/ TDF/FTC 0.79; for the combination 0.51; for ZDV/TDF/FTC 0.36; ZDV/TDF/FTC 0.29; and for ZDV/TDF/FTC 0.27.

CONCLUSIONS: The combination EFV/TDF/FTC is the most studied combination and is clinically effective at 48 weeks, with good safety profile. The administration once a day improves adherence to treatment.

PIN5

THE PREVALENCE AND ECONOMIC BURDEN OF HEPATITIS C VIRUS INFECTION IN CANADA AND LATINO AMERICA: A SYSTEMATIC REVIEW

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OBJECTIVES: The global prevalence of hepatitis C virus (HCV) infection is estimated at over 300 million persons. Despite stable prevalence, the economic burden in the United States (US) is projected to double over the next decade. Less is known, however, for the rest of the Americas. This epidemiologic and economic data are critical for decision-makers to project the impacts of HCV treatments. The objective of this study was to synthesize literature-based estimates of the prevalence and economic burden of HCV from Canada, Mexico, Brazil, Argentina, Peru, Colombia, and Chile. METHODS: A systematic review was conducted in December 2009 to determine the a) prevalence, and b) resultant economic burden, of HCV treatments. The independent reviewers extracted data from articles meeting the inclusion criteria: from EMBASE, Medline, or the Cochrane databases; focusing on general population estimates from the target countries; and published since the year 2000.

RESULTS: The search strategy identified 280 abstracts; eight provided general population prevalence estimates. In Brazil, the prevalence was estimated at 1.4% in Sao Paulo, and 3.6% in the state of Para. Canadian national surveillance programs estimated average prevalence of 0.8%; with provincial estimates from 1.3% to 2.0%. Mexican estimates ranged from 0.7% to 2.0%; the national health survey reported a prevalence of 1.4%. No prevalence estimates were identified for the remaining countries. Only one study (from Canada) assessed the overall economic burden. Despite a predicted 14 decrease in prevalence, HCV-related costs were projected to increase by over 50%, to 158 million dollars annually by 2040. CONCLUSIONS: HCV prevalence estimates varied from 0.8% to 3.6%, from general population based studies from Canada, Mexico, and Brazil. Canadian data suggest the economic burden of HCV is large, and increasing. While these data are useful for decision-makers, the paucity of data for South America highlights a substantial knowledge gap.

PIN6

TRENDS OF HEPATITIS A INCIDENCE FROM 2005 TO 2008

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In the 1996 US Advisory Committee on Immunization Practices recommended administration of hepatitis A vaccine for those at risk of infection. In 2005, the recommendation was extended to all children and at risk adults. Comprehensive data on hepatitis A in a managed care population were not available. OBJECTIVES: To evaluate the incidence of hepatitis A in a managed care population from 2005 to 2008. METHODS: This was an observational, retrospective cohort study utilizing medical and pharmacy claims data from January 1, 2005 through December 31, 2008. This data was from HealthCore, Inc., Wilmington, DE, USA, and HealthCore, Inc., Wallingford, CT, USA. The index date was defined as date of first diagnostic claim for hepatitis A within the intake period. Patients included were those aged 20 years old and had continuous eligibility for at least 12 months prior to and after index date. RESULTS: A total of 7674 patients were diagnosed with hepatitis A (51.1% male). Annual incidence was similar for