

cians were asked if they considered that the patient had CGD and also objective criteria (serum creatinine ≥ 2 mg/dl or MDRD ≤ 50 ml/min), were applied. **RESULTS:** A total of 872 patients were analyzed 62% male, mean (SD) age 54 (13) years. Etiology of end stage renal failure: 32.7% chronic glomerulonephritis, 19.8% unknown, 12.4% polycystic disease, 7.6% chronic pielonephritis, 8% diabetes, 5.9% hypertension, 15.7% other. Mean (SD) transplant evolution 8.2 (5.1) years. Mean donor age 42 years. CGD was diagnosed in 35% of the patients according to the investigators' criteria and in 55.5% according to objective criteria. In 40% of the patients that were diagnosed of CGD by objective criteria the clinician had not considered this diagnosis. Graft biopsy was performed in 31% of patients with investigators' criteria of CGD. The presence of proteinuria conducted to a biopsy more than a rise in serum creatinine. Time from transplant to biopsy was greater in patients with antiproteinuric treatment ($p = 0,032$). Immunosuppressive treatment changes were not associated to biopsy histological data. The creatinine slope showed a direct relationship with the total number of treated acute rejections (Pearson's $r: 0,12; p < 0,001$). **CONCLUSIONS:** This study shows an existing difference between the clinician's perception of CGD and its objective presence. Nephrologists are more sensitive to glomerular disease than to renal impairment itself. Changes in the immunosuppressive treatment due to presence of CGD are performed late and with poor results.

URINARY/KIDNEY DISORDERS—Cost Studies

PUK2

IN GREECE, INCREASING THE UTILIZATION OF PERITONEAL DIALYSIS THERAPY MAY REDUCE OVERALL DIALYSIS EXPENDITURES

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OBJECTIVES: The number of prevalent patients with end-stage renal disease (ESRD) in Greece has grown nearly 13% since 2003. Approximately 83% of prevalent ESRD patients are on dialysis, the rest have a functioning kidney transplant. For ESRD patients needing dialysis, two treatment options are available, hemodialysis (HD) and peritoneal dialysis (PD). Both have been shown to have similar outcomes yet most (91%) dialysis patients in Greece receive HD. The objective of this evaluation is to project a five-year impact on total direct dialysis costs if utilization of the less expensive equally, effective PD were increased to 15% of all dialysis. **METHODS:** An Excel-based budget impact model was used to estimate the impact of a shift in modality utilization. The model takes into account dialysis modality shares, annual average cost of treating patients per modality, annual ESRD growth rate, patient years at risk and years to reach new dialysis modality distribution. Cost data from a recent Greek study were used. At baseline (2007) there were 8189 patients undergoing dialysis therapy, 91% using HD and 9% using PD. Annual direct cost per patient were €36,247 for in-center HD and €30,719 for PD. We applied a 2% annual ESRD growth rate; set the target PD modality share at 15%, and that this target would be achieved in the fifth year. Total costs included equipment/infrastructure, diagnostic services, drugs and consumables, staff salaries, and operational costs/overheads. **RESULTS:** If PD utilization gradually increases to 15% by 2012, the cumulative 5-year cost would be reduced by €6.5 million. Alternatively, the savings could provide an additional 258 patient-years of dialysis treatment. **CONCLUSIONS:** In Greece, an increased use of PD can reduce the direct costs of dialysis treatment which then

provides an opportunity to use scarce health care resources on other pressing needs.

PUK3

THE COST ADVANTAGE OF INCREASING THE USE OF PERITONEAL DIALYSIS IN TURKEY

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OBJECTIVES: The number of prevalent patients with end-stage renal disease (ESRD) in Turkey has grown nearly 36% from 2001 to 2005. Approximately 90% of prevalent ESRD patients are on dialysis, the rest have a functioning kidney transplant. For ESRD patients needing dialysis, two treatment options are available, hemodialysis (HD) and peritoneal dialysis (PD). Both have been shown to have similar outcomes yet most (87%) dialysis patients in Turkey receive HD. The objective of this evaluation is to project a five-year impact on total direct dialysis costs if utilization of the less expensive equally effective PD were increased to 20% of all dialysis. **METHODS:** An Excel-based budget impact model was used to estimate the impact of a shift in modality utilization. The model takes into account dialysis modality shares, annual average cost of treating patients per modality, annual ESRD growth rate, patient years at risk and years to reach new dialysis modality distribution. Cost data from a recent Turkish study were used. At baseline (2005) there were 39,161 patients undergoing dialysis therapy, 13% using PD. Annual costs per patient were US\$23,342 for in-center HD and US\$17,779 for PD. We applied a 6% annual ESRD growth rate; set the target PD modality share at 20%, and that this target would be achieved in the fifth year. Total costs included the costs of dialysis related supplies (e.g., dialysis solutions) and the cost of drugs (e.g., erythropoietin). **RESULTS:** If PD utilization gradually increases to 20% by 2010, the cumulative 5-year cost would be reduced by \$38.8 million. Alternatively, the savings could provide an additional 2420 patient-years of dialysis treatment. **CONCLUSIONS:** In Turkey, an increased use of PD can reduce the dialysis and drug-related costs of dialysis treatment which then provides an opportunity to use scarce health care resources on other pressing needs.

PUK4

PHARMACOECONOMIC EVALUATION OF SOLIFENACIN IN THE TREATMENT OF OVERACTIVE BLADDER SYNDROME IN ITALY

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OBJECTIVES: To investigate the pharmacoeconomic performance of the treatment with solifenacin, a bladder-selective muscarinic receptor antagonist, as compared to tolterodine and placebo, in Italian patients with overactive bladder (OAB). **METHODS:** A simple Markov model simulates 52-weeks clinical and economical outcomes associated with the treatment with solifenacin (5 mg/die), tolterodine ER (4 mg/die), and no treatment, in a cohort representative of the Italian OAB population, relying on RCT efficacy and national cost data, and using 1-week cycles. Only direct health care costs were considered. The main analysis is conducted from the point of view of the patient, as drugs for OAB are not currently reimbursed in Italy, whereas incontinence medical devices are only to few selected patients. A complementary scenario was elaborated to explore the consequences of a hypothetical reimbursement decision by the Italian NHS at half of the current retail price and only to incontinent and responding OAB patients. **RESULTS:** Both active treatments produce significant improvements in symptoms and quality of