treatment regimen. Here, BDD-rFVIII patients consumed a median of 6,204 IU/kg per year while matched FL-rFVIII patients utilized a median of 4,118 IU/kg (p = 0.03). This difference could not be attributed to a higher prescribed prophylaxis dose. CONCLUSIONS: This analysis shows that BDD-rFVIII-treated patients were associated with utilizing more IU/kg/year of FVIII while on a prophylactic regimen than matched FL-rFVIII-treated patients. Further research is required to determine whether greater utilization of BDD-rFVIII during prophylaxis is associated with increased risk of breakthrough bleeds.

A POPULATION STUDY ON THE AGE-SPECIFIC RELATIONSHIP BETWEEN BODY MASS INDEX, METABOLIC DISORDERS, AND UTILIZATION OF AMBULATORY SERVICES

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OBJECTIVES: The objective of this study was to examine the age-specific relationship between body mass index (BMI), prevalence of metabolic disorders, and utilization of outpatient services. METHODS: Data for this study came from the National Health Interview Survey in Taiwan, which was conducted in 2001. With the consent of the respondents, the interview data were linked to their claims in the National Health Insurance database. The self-reported weight and height were used to calculate BMI. Diseases and utilization of outpatient services were identified from the claims data. RESULTS: A linear trend of prevalence was observed with increments of BMI. The same trend was observed for the number of visits to outpatient clinics. The BMI-related medical expenditures did not reach statistical significance. Nevertheless, age was an important factor. After controlling for the number of chronic diseases, the relationship between BMI and utilization of outpatient services disappeared. CONCLUSIONS: The BMI-related medical expenditures pertained to metabolic disorders, such as hypertension, diabetes, and ischemic heart diseases. A health promotion program should prevent the diseases, thus reducing medical expenditures.

PREDICTING FACTORS FOR METABOLIC SYNDROME AMONG US ADOLESCENTS 12–17 YEARS OF AGE

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OBJECTIVES: To contrast the factors that are associated with metabolic syndrome risk for US adolescents overall and US Hispanic adolescents. METHODS: At risk is defined as having three or more of the following: elevated fasting glucose, elevated SBP, elevated DBP, elevated triglycerides, elevated BMI, elevated waist circumference, or low HDL. Logistic regression and NHANES 2003–2006 data were used to examine the impact on metabolic syndrome risks; gender, race, ethnicity, immigrant status, income, insurance, parental education, activity levels, number of school lunches and breakfasts per week, milk consumption, language preference, and number of meals outside the home per week. US adolescents overall are compared with US Hispanic adolescents. A significance level of 0.05 was used. Weighted sample sizes for Hispanic adolescents and US born adolescents are 8,178,714 and 50,837,204 respectively. RESULTS: The results of the regressions were vastly different between US adolescents and US Hispanic (First Generation and Native) adolescents. All variables in the models are significant. Major differences include the decreased risk (42%) for US adolescent females overall, and the increased risk (17%) for US Hispanic females. Notably, for those Hispanics that are first generation, their risk is increased by 65%. For US adolescents overall, low or middle income levels increase risk three times, while low and middle income level US Hispanic adolescents have a risk decrease of 77% and 69% respectively. For every meal eaten outside the home per week (excluding school meals) the risk increases for US adolescents by 4% and by 13% for Hispanic US adolescents. CONCLUSIONS: These adolescents are at risk for acute cardiovascular endpoints, higher medical utilization and expenditure, and lower quality of life. Interventions should focus on education regarding healthy eating outside the home with limited resources. A surprising result of this analysis is the high price of acculturation for Hispanic first generation adolescents.

INCREASING SAVINGS ASSOCIATED WITH A DECREASE IN ANTIDEPRESSANT MEDICATIONS FOLLOWING BARIATRIC SURGERY IN WESTERN NEW YORK

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OBJECTIVES: To estimate the incremental costs following bariatric surgery, with regard to antidepressant use. METHODS: Data was collected for body weight, mental health status such as depression, medication use and counselling for one hundred subjects pre and post bariatric surgery from 2006–2007. Measures of mental health were compared before and after surgery. Cost estimates for the management of depression were based on data published in 2000. RESULTS: Patients lost a mean value of 52% of their excess body weight. Following surgery, the proportion of depressed patients decreased by 46%, the proportion of the patients on antidepressants decreased by 30%, and the proportion of those who utilized counselling services decreased by 19%. When applying cost estimates for managing depression, total incremental savings in depression management were $6,527 (average per patient per year estimate). CONCLUSIONS: Bariatric surgery is a costly procedure estimated at $22,213 per procedure. Results from a Western New York center based on 100 patients suggest that reduction in depression and the associated medication and counselling use provide incremental savings of $6,527 (per year) for the patients who have the procedure. In addition, co-morbidities associated with obese patients such as diabetes, hypertension, sleep apnea, and venous insufficiency offer further incremental savings which is likely to offset the cost of the bariatric surgery, possibly leading to savings. Long-term outcomes of bariatric surgery and the associated incremental cost were not evaluated in this study. Future research should consider long-term outcomes and associated costs from the societal, payer and patient perspectives. Maintaining the weight loss over the long-term is likely to lead to significant cost savings from all perspectives and improved quality of life.

A NATURAL EXPERIMENT TO ESTIMATE THE IMPACT OF A PREFERRED DRUG LIST POLICY FOR LONG ACTING NARCOTIC ANALGESICS ON COSTS AND UTILIZATION

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OBJECTIVES: On October 26, 2005, Arkansas Medicaid implemented a preferred drug list (PDL) policy for long acting narcotic analgesics (LANA) where only generic long-acting morphine and methadone could be obtained without prior-approval. The objec-
tive was to determine the impact of the PDL on net costs and utilization of LANA, total narcotic analgesics, and non-narcotic substitute drugs. METHODS: We obtained Arkansas Medicaid claims data from January 2003 to July 2007. Net costs based on CMS-rebates and mg of morphine equivalents (MEq) obtained from standardized conversion tables were the primary outcome variables. Autoregressive-integrated-moving-average ARIMA time series models of monthly measures were estimated. Interrupted OLS time series models were estimated to capture the impact of the policy on the shifts in trend and intercept.

RESULTS: There were 709,791 Medicaid eligibles, of which 3,227 used a LANA whom had an average age of 44.65 years, 39.36% male, and 80.54% white. The PDL was associated with a $1.41 million (95%CI: $0.37–$2.43 million) and a $1.78 million (95%CI: $0.48–$3.05 million) cost reduction for LANA and total narcotic analgesics over the 22-month post-policy period. Total narcotic utilization was not significantly different than trend utilization for 18 months of the post-policy period. The PDL was associated with a significant increase in C-II short-acting narcotic utilization of 202,828 (95%CI: 68,160–337,497) MEq and non-significant decreases in C-II LANA and CIII-V narcotic utilization. A sensitivity analysis with a term to capture the effect of generic fentanyl availability yielded more conservative cost saving estimates. There was no PDL-related increase in the utilization of benzodiazepines, migraine agents, NSAIDs, muscle-relaxants, anticonvulsants, or antidepressants.

CONCLUSIONS: The PDL resulted in significant cost savings for narcotic analgesics. The policy did not consistently affect the overall level of narcotic analgesia prescribed, however, the policy may have steered patients toward shorter acting narcotics.

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PATIENT-REPORTED OUTCOMES (PRO’S) AND ECONOMICS OF NEUROPATHIC PAIN IN GERMANY
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OBJECTIVES: To evaluate health care resource use, costs and patient-reported outcomes (PRO’s) among patients with neuropathic pain, specifically for guideline-, non-guideline- and self-treatment-groups in Germany. METHODS: Patients were consecutively recruited by physicians in general practice (n = 47) in 2005. Data on resource utilization due to neuropathic pain was collected retrospectively for six months. Costs were estimated from the societal perspective. PRO were assessed through the generic SF-36, and the disease-specific Hannover Functional Questionnaire (FFbH), for six months. Patients completed the generic SF-36, the health status questionnaires, and PRO as evalu-ated using multivariable general linear modeling (GLM).

RESULTS: Ninety-nine patients (n = 44 self-treatment, n = 29 guideline-, n = 44 non-guideline-groups) were on average 54 years old, 64% of them were women. Patients with self-treatment were younger, more likely to be employed and had lower BMI than patients in guideline or non-guideline-group (mean age 49.8 vs. 59.4 vs. 57.4 years; mean BMI 24.9 vs. 28.2 vs. 26.8). Average duration of back pain was about 7.3 years and was comparable among the groups. The groups differed regarding the SF-36, the von Korff Index and Patient Health Questionnaire Depression (PHQ-D) forms at the time of enrollment. Groups were compared using multivariable general linear modeling (GLM).

RESULTS: Patients (n = 72 self-treatment, n = 29 guideline-, n = 44 non-guideline-groups) were on average 54 years old, 64% of them were women. Patients with self-treatment were younger, more likely to be employed and had lower BMI than patients in guideline or non-guideline-group (mean age 49.8 vs. 59.4 vs. 57.4 years; mean BMI 24.9 vs. 28.2 vs. 26.8). Average duration of back pain was about 7.3 years and was comparable among the groups. The groups differed regarding the SF-36, the von Korff index, FbH-R and frequency of PHQ-D somatiform symptoms. The self-treatment group reported the highest mean physical component of the SF-36 compared to other groups (39.6 ± 10.4, p = 0.0011, adjusted by age). Mean total societal perspective costs per patient were ($417.61 [95%CI 171.03; 664.18] vs. $3159.17 [95%CI 933.62; 5384.73] vs. $640.58 [95%CI 818.02; 2463.13], self-treatment-vs. guideline vs. non-guideline-group, respectively). The major cost factors were: in the self-treatment-group, reduction of earning capacity (43.4%), sport activities (26.9%), and remedies (19.3%); in the guideline-group, sick leaves (64.0%), prescribed medications (10.1%), and visits to physicians (6.2%); and in the non-guideline-group, sick leaves (23.8%), remedies (20.7%), and reduction of earning capacity (12.7%). CONCLUSIONS: PRO seem to be better in the self-treatment-group, reduction of earning capacity (43.4%), sport activities (26.9%), and remedies (19.3%); in the guideline-group, sick leaves (64.0%), prescribed medications (10.1%), and visits to physicians (6.2%); and in the non-guideline-group, sick leaves (23.8%), remedies (20.7%), and reduction of earning capacity (12.7%). The major cost factors are different among guideline, non-guideline and self-treatment-groups, while costs are positively related to age and unemployment.

URINARY/KIDNEY DISORDERS— Clinical Outcomes Studies

PUKI
CLINICAL ATTITUDES ON CHRONIC GRAFT DYSFUNCTION: THE ICEBERG STUDY
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OBJECTIVES: Renal impairment after transplant is associated to a greater risk of death. It is of interest to assess how and when the diagnosis is made. To evaluate the diagnostic method of renal dysfunction (Clinical or Histological). METHODS: Observa-tional and multicenter study including 872 renal transplant patients with at least two years post-transplant. Data were re-spectively collected at five point since transplant. Clinical