EVALUATION OF IMPROVEMENT IN HEALTH-RELATED QUALITY OF LIFE USING ORAL MESALAZINE ALONE OR IN COMBINATION WITH A MESALAZINE ENEMA IN ACTIVE ULCERATIVE COLITIS: RESULTS FROM A RANDOMISED CONTROLLED TRIAL

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OBJECTIVES: The purpose of this study was to evaluate the impact of mesalazine on patient reported QoL when administered either orally or in combination with topical treatment in patients with acute, mild-to-moderate ulcerative colitis (UC).

METHODS: Data was from a randomised controlled trial where patients received daily treatment of either 4 g oral mesalazine plus 1 g enema mesalazine (MES+), or 4 g oral mesalazine plus a placebo enema (MES−). Oral treatment was given for 8 weeks (the trial period) and enema treatment for the initial 4 weeks only. QoL was measured using the EQ-5D and administered at baseline, 2, 4, and 8 weeks. The Mann-Whitney test was used to compare means.

RESULTS: 127 subjects were randomised: 60% male, mean age 43.5 years and mean EQ-5D index value 0.765 (SD 0.16). The baseline EQ-5D was 0.780 (SD 0.20) in the MES+ arm and 0.745 (SD 0.16) in the MES− arm (p = 0.27). Rapid improvement in QoL was evident in both treatment arms at 2 weeks with change from baseline ΔB = 0.079 (p < 0.001) in the MES+ arm and ΔB = 0.097 (p = 0.03) in the MES− arm. However, a near normal QoL was achieved more quickly in the MES+ arm, whereby the mean QoL at 4 weeks was 0.921 (SD 0.14), versus 0.859 (SD 0.17) in the MES− arm (p = 0.034). At 8 weeks, substantial improvement in QoL was evident in both treatment arms with almost normal QoL compared to the UK standard population (MES+: mean = 0.922, ΔB = 0.15 [p < 0.001] and MES−: mean = 0.920, ΔB = 0.16 [p < 0.001]).

CONCLUSION: Treatment with mesalazine resulted in improved QoL as measured using the EQ-5D. Near normal QoL was achieved by 8 weeks in the two treatment arms but it was achieved much faster with combination treatment of oral and enema mesalazine. Consequently combination oral and enema therapy should be offered as first line therapy for patients with mild-to-moderate UC.

MICRO-COSTING OF SURGICAL PROCEDURES RELATED TO INTRACEREBRAL HAEMORRHAGE IN A UK HEALTH CARE SETTING

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OBJECTIVES: The UK has recently implemented a system of prospective payment for episodes of care (Health Related Groups). When conducting economic evaluations alongside clinical trials, costs for episodes of care may not prove adequate estimates for procedure costs. The purpose of this study was to collect data on resource use for procedures related to intracerebral haemorrhage (ICH) and calculate their respective cost.

METHODS: A questionnaire was developed to capture resource use for 15 surgical procedures related to ICH. This covered all aspects of inpatient treatment including theatre time, inpatient consultations, rehabilitative therapy, disposables, diagnostic investigations, drugs and length of stay (LOS). Three UK consultants with a speciality in ICH responded to the questionnaire. Using a bottom-up costing approach, unit costs from publicly available sources were ascribed to each resource, which were summed to calculate the total average cost per procedure.

RESULTS: The average cost of major ICH procedures—aneurysm clipping, aneurysm coiling, craniotomy for haematoma and decompressive craniectomy—was £11,473, £12,220, £12,113 and £18,650, with LOS being the primary cost driver (44–75% of total costs, ranging between £5,389 and £12,616). The exception to this was aneurysm coiling, where LOS was reduced but the coils themselves accounted for 30% of total cost making the procedure slightly more expensive than the most common alternative of aneurysm clipping. For secondary procedures, costs ranged between £1,646 for tracheostomy and £6,823 for burrhole aspiration of haematoma. LOS remained the dominant factor but consumables played a significant role contributing an average of 37% to total costs.

CONCLUSION: LOS is the main cost driver for procedures related to acute care for ICH, followed by consumables. Cost estimates obtained through micro-costing can be used for trial-based economic evaluations. They could also assist physicians and hospital administrators to better understand the true impact of procedures on real hospital spending.