Mean total QALYs varied by the MDD treatment pattern (6-month duration): Escitalopram (0.1682 QALYs), venlafaxine (0.1787 QALYs), alprazolam (0.1776 QALYs) and lorazepam (0.1755 QALYs). The 12-week expected mean costs per patient were US$3,064.35 ± US$3,311.33 for escitalopram, US$3,152.6 ± US$483.3 for venlafaxine, US$3,152.6 ± US$370.3 and US$3,165.3 ± US$626.4, respectively following the last order above. The ICER for escitalopram versus venlafaxine (baseline) was US$465.7 for HAM-A and US$26,075.7 for QALYs. Escitalopram dominated lorazepam and alprazolam (p = 0.05). First-order Monte Carlo sensitivity analyses showed robustness and that escitalopram was the most cost-effective therapy using international thresholds. CONCLUSIONS: Escitalopram showed to be a cost-effective and cost-saving therapy in the management of Mexican patients with GAD.

**PMH23**

**COST-EFFECTIVENESS OF ESCITALOPRAM VERSUS VENLAFAXINE IN SECOND-LINE TREATMENT OF MAJOR DEPRESSIVE DISORDER (MDD) IN SWEDEN**

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OBJECTIVES: The present cost-effectiveness analyses compare escitalopram versus duloxetine in second-line treatment in patients with MDD. Sensitivity analyses were performed to make efficient clinical decisions.

METHODS: A decision model was based on second-line MDD treatment patterns (6-month timeframe). Effectiveness outcomes were sustained remission (the Montgomery-Asberg Depression Rating Scale (MADRS) ≤ 10) and QALYs. Costs for antipsychotic and antidepressant treatment, to inform the clinical decision making on second-line treatment therapy choice. RESULTS: A model decision was made on second-line MDD treatment patterns (6-month timeframe). Effectiveness outcomes were sustained remission (the Montgomery-Asberg Depression Rating Scale (MADRS) ≤ 10) and QALYs. Costs for antipsychotic and antidepressant treatment, to inform the clinical decision making on second-line treatment therapy choice. CONCLUSIONS: Escitalopram is cost-effective versus venlafaxine and duloxetine in second-line treatment of MDD in Sweden. The sustained remission rate and QALYs are associated with cost savings and support the use of escitalopram following failure of first-line treatment. MGH cost category: 3.5-4.2, 4.5-5.5, 5.5-6.4, 6.5-7.4, 6.1-7.1 (p < 0.01). CONCLUSIONS: TRD is a costly disorder and merits consideration as interventions are developed to manage the burden of disease and improve productivity. Even patients with less complex forms of TRD have costs far in excess of those without TRD. Dichotomous definitions of TRD may not be adequate; a gradient from moderate to complex TRD may be more useful for providers and insurers.

**PMH24**

THE COST BURDEN OF TREATMENT RESISTANCE IN PATIENTS WITH DEPRESSION

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OBJECTIVES: Many patients on antidepressants are not responsive to first-line therapy (‘treatment-resistant’ depression (TRD)) and can undergo switches and optimizations to discover a beneficial therapeutic regimen. While patients with most complex forms of TRD have higher costs than non-TRD patients, little is known about the cost effects for patients across a gradient of TRD classifications (from moderate to complex). METHODS: Patients aged 18–64 years in employer-sponsored plans with at least 12 months of continuous medical and prescription coverage and at least one antidepressant prescription were found in the 2000–2006 MarketScan Database (n = 78,476). An MGH TRD scale value (range from 0 to 165.1) was calculated for each patient and a value exceeding 3.5 indicated TRD. Twelve-month direct medical and prescription drug expenditures for patients with TRD (n = 22,539) were compared to expenditures among an equal number of propensity-score matched patients with non-TRD depression. Propensity scores were estimated via demographic characteristics and case-mix. Generalized linear models (gamma family and log link) controlled for demographic and case-mix factors. RESULTS: Average 12-month direct medical care and prescription drug expenditures were almost 40% higher for TRD ($9470 compared to matched non-TRD patients ($8613) (p < 0.01). One-unit increase in TRD score was associated with a $772 increase in annual costs (p < 0.01). Compared with a matched group of non-TRD patients, annual costs for patients were higher in each MGH cost category: 3.5-4.2, 4.5-5.5, 5.5-6.4, 6.5-7.4, 6.1-7.1 (all p < 0.01). CONCLUSIONS: TRD is a costly disorder and merits consideration as interventions are developed to manage the burden of disease and improve productivity. Even patients with less complex forms of TRD have costs far in excess of those without TRD. Dichotomous definitions of TRD may not be adequate; a gradient from moderate to complex TRD may be more useful for providers and insurers.

**PMH25**

OBJECTIVES: Schizophrenia, influencing approximately 1% of the population, is a chronic psychiatric disease with a substantial health and economical burden for patients, care givers, and society. Despite this, however, its economic burden is often overlooked and/or not widely known in many countries. This study aims at estimation of cost of schizophrenia treatment in an inpatient facility in Turkey. METHODS: The study has been conducted in Manisa Mental Diseases Training and Research Hospital, one of the largest of its type in Turkey. Electronic hospital records of 4177 schizophrenia patients between June 2006 and June 2007 were retrospectively analyzed to calculate the total schizophrenia treatment cost per hospitalization where only direct costs were included. Cost items included in the analyses were antipsychotic and concomitant medication costs, adverse event treatment costs, bed costs, and laboratory/ radiological examination costs. Average length of stay per hospitalization was calculated. The results were presented as disease and total costs. Direct costs were derived from administrative claims from a multi-specialty medical group hospital in electricity, gas, water, and facility purchases. The cost effects for patients along a gradient of TRD classifications (from moderate to complex). MGH cost category: 3.5-4.2, 4.5-5.5, 5.5-6.4, 6.5-7.4, 6.1-7.1 (all p < 0.01). CONCLUSIONS: TRD is a costly disorder and merits consideration as interventions are developed to manage the burden of disease and improve productivity. Even patients with less complex forms of TRD have costs far in excess of those without TRD. Dichotomous definitions of TRD may not be adequate; a gradient from moderate to complex TRD may be more useful for providers and insurers.
practice in central Massachusetts were used to identify 1777 patients age 26-65 years as of January 1, 2006 with continuous medical and pharmacy coverage in 2005 (baseline) and 2006 (study period) and 2 depression diagnosis in 2005. Patients with an antidepressant claim in 2006 were classified as “treated” and those without an antidepressant claim were classified as untreated. Depressed patients were randomly matched to controls without depression on age and gender. Baseline comorbidity profiles were compared using Chi-square tests. Wilcoxon rank-sum tests and generalized linear models were used to compare study period direct (medical and pharmacy) costs defined as third party payments to providers. Depression-related costs were identified using claims with depression diagnosis and antidepressant prescriptions. RESULTS: A total of 1334 (75.1%) of depressed patients were treated with antidepressants during the study period and 443 patients (24.9%) were not treated. Depressed patients were on average 77 years of age and women. Depressed patients had higher rates of mental health and physical comorbidities than controls. Treated depressed patients had higher rates of mental health comorbidities than the untreated but few differences in rates of physical comorbidities. During the study period average annual direct costs were $14,362 among treated depressed patients, $8,928 among the untreated, and $6,963 among controls (P < 0.01 for all comparisons). Risk-adjusted direct costs were significantly different between the treated and untreated depressed. Average depression-related costs were $1,582 among the treated and $133 among the untreated (P < 0.01). CONCLUSIONS: Older depressed patients (both treated and untreated) had more comorbidities and higher costs compared to controls. Costs and rates of mental health comorbidities were higher among the treated depressed compared with the untreated. PMH10 HOSPITALIZATION COSTS FOR SCHIZOPHRENIA RELAPSES IN A PUBLIC PSYCHIATRIC INSTITUTION Verdeja-Wong Vivian P1,2,3, Anapo P3 1Mexican Social Security Institute, Mexico City, Mexico, 2Mexican Social Security Institute, Mexico City, Mexico, 3Ingenix Impact Database, Mexico City, DF, Mexico. OBJECTIVES: To estimate hospitalization costs as well as resources used by schizophrenic patients during a relapse in a public psychiatric hospital. METHODS: A documental retrospective analysis of schizophrenia patients with a relapse as the principal diagnosis was carried out in a public psychiatric hospital in Mexico. The range of patients’ age was from 18 to 64 years. Data was collected by a General Physician through a Case Report Form designed specifically for this study. Resources used during relapse hospitalization were accrued and final costs were calculated using unitary costs of the Mexican Social Security Institute (IMSS) for laboratory studies, physician's visit, emergency admittance and bed day. Drug costs were obtained from public bidding and Internet. Results are presented using descriptive statistics. Costs are in US dollars using and exchange rate of 13.5 MXN pesos for 1 US dollar. RESULTS: Sample size was 73 patients with an average follow up of 3.3 years. Hospital average length of stay was 20.65 days (4-108), average time between relapses was 14.66 months (6.47-25.73). The average cost per day was $346 (95% CI $331-$360), 96% of this cost represents the average bed day cost reported by the IMSS. The average cost per relapse was $7,086 ($1,498-$36,288). Alcoholism and hypertension were the main comorbidities reported in 10.8% of admitted patients. Lack of compliance was the reason for relapse in 95% of the cases. CONCLUSIONS: Bed day cost is the main component of total costs, therefore it would make sense to use those antipsychotic drugs that help reduce the hospital length of stay. The lack of compliance is responsible for the vast majority of relapses (95%). A health care program focus in increasing drug compliance could decrease institutional general costs by reducing hospitalizations due to relapses. ASSOCIATION BETWEEN CHOICE OF ANTIPSYCHOTIC TREATMENT AND SUBSEQUENT COSTS OF MEDICAL CARE IN PATIENTS WITH BIPOLAR DISORDER Mychlakiew MA1, Sanders KN2, Ahir J1, Monsanto LB1, Lenhart G2, O’Gorman C2 1The New York, NY, USA, 2Thomson Reuters, Washington, DC, USA. OBJECTIVES: Efficacy in bipolar disorder (BPD) has been demonstrated for various atypical antipsychotics (APs). Treatment choice is based on factors including patient history and clinician preference. Because cost of patient care is often a factor in this study, the association between AP treatment choice and subsequent medical care costs was studied. METHODS: Patients with BPD and AP treatment were identified in the 2004-2005 PharMetrics Patient-Centric Database. Patients were stratified by the most-recently prescribed AP and retained with ≥12 months continuous enrollment before and after their earliest AP claim. Total medical care costs were calculated as paid claims for 12 months post AP initiation. Multivariable analyses controlled for differences between cohorts. RESULTS: AP patient cohorts were ziprasidone (n = 925), olanzapine (n = 2526), risperidone (n = 2309), quetiapine (n = 2860) and aripiprazole (n = 747). Mean age was 39-42 years. ZIPRA patients were more likely to be female. Approximately 25% of the sample had comorbid anxiety and 10% had alcohol abuse. The majority had concomitant medication use. After controlling for covariates, the ziprasidone group’s 12-month post-initiation total costs ($14,445) were similarly increased costs ($13,358, p = 0.06) and olanzapine ($13,780, p = 0.24, p < 0.001). Older age, female gender, pre-index psychiatric admission, comorbidities, and concomitant medication were significantly associated with increased costs. Nevertheless, unadjusted results were similar to multivariable findings. CONCLUSIONS: Twelve months follow- ing treatment initiation for BPD, total medical care costs for patients on ziprasidone were comparable to those for patients on olanzapine or risperidone, and, significantly lower than costs for patients on quetiapine or aripiprazole. If cost is a factor in AP treatment choice, the findings support ziprasidone compares favorably.