practice in central Massachusetts were used to identify 1777 patients age 265 years as of January 1, 2006 with continuous medical and pharmacy coverage in 2005 (baseline) and 2006 (study period) and 21 depression diagnosis in 2005. Patients with 21 antidepressant claim in 2006 were classified as “treated” and those without an antidepressant 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 441 patients (24.9%) were not treated. Depressed patients were on average 77 years old and were 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.

HOSPITALIZATION COSTS FOR SCHIZOPHRENIA RELAPSES IN A PUBLIC PSYCHIATRIC INSTITUTION

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OBJECTIVES: To estimate hospitalization costs as well as resources used by schizophenic 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’ ages 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 bodies and private institutions. 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 (6.67–25.73). The average cost per day was $346 (95% IC $313–$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 hypothermep was the main comorbidities reported in 10.8% of admitted patients. Lack of compliance was the reason for relapse in 95% of the cases. CONCLUSIONS: Red 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

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OBJECTIVES: Efficacy in bipolar disorder (BDP) 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 choice, the association between AP treatment choice and subsequent medical costs may be important. METHODS: Patients with BDP 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 tallied and paid claims for 12 months post AP initiation. Multivariable analyses controlled for differences between cohorts. RESULTS: AP patient cohorts were ziprasidone (n = 825), olanzapine (n = 2526), risperidone (n = 2309), quetiapine (n = 2860) and aripiprazole (n = 1397). Mean age was 39–42 years. Ziprasidone 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 similar to the others ($13,358, p = 0.6) and olanzapine ($13,780, p = 0.24), and lower than quetiapine ($15,740, p = 0.03) and aripiprazole ($16,360, p = 0.01). 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 fol-

LOWING treatment initiation for BDP, 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 suggest ziprasidone compares favorably.