primary care (range: 10%–94%) than in general hospitals (range: 5.8%–43.3%), and highest in specialist nephrology settings (range: 36.0%–97.6%). All-cause mortality rates increased with the CKD stage (2: 1–14%–27%; 3: 25.5%–91%; 4: 36.0%–85.5%; 5: 97.6%). The cost of managing anaemia per patient per year varied across studies from $2,616 (2006–2007 Great British Pounds; GBP) to $740 (2006 GBP) in the UK, to $6,609 (2006 USD) in the United States (7 panels reviewed). Overall cost of managing anaemia was highest in patients with CKD Stage 3 compared with other stages (3: 4,162,056 vs. 4: $2,453,288, 2006–2007 GBP). Another study reported higher costs per patient per annum for individuals with lower haemoglobin (Hb) levels (Hb ≤12 g/dL; $2,418; Hb <10 g/dL; $13,005; cost year not reported). Among patients with CKD, those with anaemia were more likely to be hospitalised (61% vs. 50% of those without anaemia). CONCLUSIONS: Anaemia is a highly prevalent condition in CKD across all countries and stages of disease, and the evidence available suggests it is associated with a substantial economic burden.

**OBJECTIVES:** To estimate health and social care resource use in treating individuals with Ph+ leukemia in Canada and the United Kingdom; FKS is the most common inherited form of intellectual disability (ID) worldwide; however its impact on resource use is not well documented. METHODS: Delphi panels were formed to generate consensus-based estimates of resource use. Panels consisted of 2 groups (7 panels reviewed) and a questionnaire was developed to obtain estimates from each panelist by age groups, 2 severity levels and 24 service types for each of 9 items from the Aberrant Behavior Checklist (ABC) inventory. RESULTS: The panelists were experts in the care of individuals with ID. A factor weight was estimated to differentiate costs by gender and a self-declared confidence score (1 – 5) was reported for each ABC item. Mean total service counts and coefficients of variation (CV) were calculated to assess variation between panelists and between rounds. Initial results were reviewed with panelists in a facilitated group discussion after which the questionnaire was repeated. Final data were based on the second round of estimation. CONCLUSIONS: Comprehensive resource use data were collected for both countries. There was lower variance and higher confidence in both countries in round 2 compared to 1. Rounds 1 and 2 means (CV) for Canada were [6,723 (6.9), 5,757 (5.02)] and for UK were [6,953 (9.6), 6,023 (7.6)]. The average level of self-declared confidence for each question exceeded 4 (on a 5-point scale). The study generated comprehensive resource use data for treating individuals with FKS in Canada and the UK. Credible and validated estimates were generated through group discussion and refinement of initial estimates for patients with FKS.

**PSY29** IMPACT OF BARIATRIC SURGERY ON OBESITY PATIENTS MANAGEMENT AND RELATED COSTS: A FRENCH NATIONAL CLAIMS DATABASE ANALYSIS OVER THE PERIOD 2005 - 2011

Czernichow S, Emery C, Fagnani P, Gourmelen J, Swawecrenstein K, Lafauma A, INSERM, Villejuif, France, 2Cemka Eval, Bourj La Reine, France, 3HECÔME SAS, Iasy Le Moulin, France

OBJECTIVES: To gain an understanding of the impact of bariatric surgery on the current medical management of obese patients. METHODS: The EGB database is a 1/97 representative sample (around 600,000 individuals) of the national claims database covering a large proportion of the French health care system. Inclusion criteria were: BMI ≥35 kg/m², adult patients treated for the first time over the period 01/01/2007 to 31/12/2009 by bariatric surgery were included. RESULTS: A total of 8,104 patients met the inclusion criteria and were included in the database with a mean age of 38.9 years (± /-11.3 years), 83.4% female and 69.7% had a BMI in the range 40-50. The distribution of patients according to bariatric procedure was gastric banding (63.6%), gastric by-pass (19.7%), sleeve gastrectomy (16.6%) and biliopancreatic diversion (3.1%). The annual per capita reimbursed health expenses evolved from 2,633€ (+/- 3,124€) in Year (T-2), to 3,557€ (+/- 3,800€) in Year (T-1), to 4,240€ (+/- 3,840€) in Year (T+1) (excluding procedure cost) to 3,755€ (+/- 3,031€) in Year (T+2). In 39% of patients those costs decreased between T-2 and T+2, (+5%) and the only two variables significantly explaining this decrease were the reduction of consumption for anti-Diabetes and/or anti-Hypertension drugs. Most of those medical consumption increases occurred over the period pre and post procedure but started to decrease in Year T+2. CONCLUSIONS: The visits for preparing bariatric surgery were probably an opportunity for those patients to benefit from a general check-up which has generated extra short term medical consumption. Additionnal research could better capture the benefits of bariatric surgery on medical consumption.

**PSY30** COST-CONSEQUENCE ANALYSIS OF A TREATMENT STRATEGY INCLUDING PONATINIB COMPARED TO A TREATMENT STRATEGY INCLUDING ONLY THE 2nd GENERATION TYROSINE KINASE INHIBITORS (2G TKI), DASATINIB OR Nilotinib, in Resistant Patients with PHILADELPHIA CHROMOSOME-POSITIVE (Ph+) LEUKEMIA, IN ITALY

Chiolero R, Fumensi G, Panza F, 1TARIS Farmacopelie (Europae) Sàrl, Lausanne, Switzerland, 2Italian National Research Center on Aging, Ancona, Italy, 3Università Federico II, Napoli, Italy

OBJECTIVES: To assess treatment cost and duration of major cytogenetic response (MCyR) using ponatinib in patients intolerant or resistant to 2G TKI, compared to treating with only 2G TKIs, in patients with Ph+ leukemia, in Italy. METHODS: A 3-year Markov model with 1-year cycles simulated patients with Ph+ leukemia to estimate outcomes in those eligible for ponatinib therapy, defined as 1) 2G TKI-resistant, 2) 2G TKI-intolerant if imatinib is not clinically appropriate, or 3) with T315I mutation. Eligible patients received treatment sequences including 2G TKIs and ponatinib in the ponatinib arm and 2G TKI only in the comparator arm. MCyR was defined as the point reached to the next therapy line after TKI options were exhausted, then to best supportive care. MCyR rates for 2G TKI or ponatinib were estimated from clinical trial data and expert opinion. Patients were assumed to occur MCyR (3 months) until estimated treatment failure. Monthly treatment costs reflected approved EU dosing and list prices; cost of ponatinib was assumed equivalent to the US. RESULTS: We estimated 184,280, and 360 ponatinib-eligible patients in years 1,2, and 3 respectively. Treatment with ponatinib alone was associated with a $358.51 million and a total of 2,536 months in MCyR, at an average cost of $23,068/MCyR month. Using ponatinib in eligible patients costs $79.54 million and provided 5,649 months in MCyR, at an average cost of $14,079/MCyR month. CONCLUSIONS: The treatment strategy includ-