macular degeneration (AMD). METHODS: A systematic review of literature was conducted. The bibliographic search covered the period between January 1996 and January 2019. The search was run on MEDLINE, EMBASE, Cochrane library, INaltura and ECRl. The criteria employed to select the papers were: population (AMD patients), treatment (Ranibizumab or Bevacizumab), comparison (placebo or other active treatments). To assess the efficacy, it was decided to include systematic reviews and clinical trials (RCT). For safety, it was considered any type of study. RESULTS: The bibliographic search retrieved 731 references of articles and 51 papers were finally included: 4 were controlled clinical trials: two on Ranibizumab and two on Bevacizumab. Efficacy: Ranibizumab and Bevacizumab, as compared to placebo as to Verteporfin, gets results in terms of AMD stabilization (between 0.2% and 1.2% of visual losses as opposed to 13-15% in the control groups), in terms of reduction in the lesion size and it even achieves improvement in visual acuity in some cases. Safety: The adverse effects (of any magnitude) were more frequent in the groups treated with Ranibizumab and Bevacizumab than in the control groups and Verteporfin. The adverse effects similar in both drugs. Economic Evaluation: Drug costs for 1 year of treatment were estimated as 2.33€/d for Ranibizumab and 5.6€/d for Bevacizumab. CONCLUSIONS: Both drugs provide starting benefits in the treatment of age-related macular degeneration (AMD). Cost-effectiveness analysis of bevacizumab makes this intervention highly cost effective versus ranibizumab. The price of ranibizumab would have to be drastically reduced for it to be cost effective. Public pressure may be the most potent weapon in persuading Genentech to license bevacizumab for AMD.

PSS12
C-REALITY (CANADIAN BURDEN OF DIABETIC MACULAR EDEMA) OBSERVATIONAL STUDY: THREE-MONTH FINDINGS
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OBJECTIVES: To characterize the economic and societal burden of Diabetic Macular Edema (DME) in Canada. METHODS: Patients with clinically significant macular edema (CSME) were enrolled by ophthalmologists or retinal specialists across Canada. Patients are followed over a 6-month period to combine prospective data collected during monthly telephone interviews and at sites at months 0, 3 and 6. Visual acuity (VA) is measured and DME-related health care resource information is collected. Patient health-related quality of life is measured using the National Eye Institute Visual Functioning Questionnaire (NEI VFQ-25), and the EuroQol Five Dimension (EQ-5D) at baseline and month 3 results are available and presented here. RESULTS: A total of 145 patients [mean age 63.8 years (range: 30-86 yrs); 52% male; 81% Type 2 diabetes; mean duration of diabetes 18 years (range: 1-62 yrs); 72% bilateral CSME] were enrolled from 17 sites across 6 provinces in Canada. At baseline, the mean VA was 20/60 (range: 20/20-20/800) across all eyes diagnosed with CSME (249 eyes). Sixty-eight percent of patients had VA severity in the worse seeing eye of normal/mild vision loss (VA 20/20 to 5/20), 19% moderate vision loss (VA > 20/80 to 20/200), and 13% severe vision loss/nearly blind (VA > 20/200). At month 3, the mean NEI VFQ-25 composite score was 79.9, the mean EQ-5D utility score was 0.79, and the EQ visual analogue scale score was 70.6. The average 3-month DME-related cost per patient was €7,148 across all patients (95% confidence interval: €7,148 to €8,180). The cost was €1,390 for patients with normal/mild vision loss, €1,831 for patients with moderate vision loss, and €1,467 for patients with severe vision loss/nearly blind. CONCLUSIONS: DME is associated with limitations in functional ability and quality of life. In addition, the DME-related cost is substantial to the Canadian health care system.

PSS13
ECONOMIC BURDEN OF PSORIASIS AND DIABETES IN PATIENTS WITH PSORIASIS IN THE UNITED STATES
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OBJECTIVES: Psoriasis, an immune mediated disorder with skin manifestations and comorbidities, has high resource requirement. Specifically, diabetes is highly prevalent in psoriasis patients and may represent a substantial incremental economic burden. This retrospective study aimed to estimate the incremental costs of psoriasis and diabetes in psoriasis patients. METHODS: Adult patients with psoriasis (i.e., ≥2 psoriasis diagnoses ICD-9 codes: 696.1x) were selected from a large US administrative claims database. Psoriasis-free controls were matched with the psoriasis sample by age and gender in a 1:1 ratio. All patients were followed for one year to assess their healthcare costs. Incremental total healthcare costs (USD 2010) associated with psoriasis and diabetes in a psoriasis population, measured from a third-party payer perspective, were estimated using regression models controlling for age and gender. RESULTS: A total of 106,128 matched pairs were studied. Among psoriasis patients, 16% had diabetes compared to 13% of the psoriasis-free controls (p < .001). Psoriasis was associated with a $4,523 adjusted incremental total health care costs among patients with diabetes ($10,017 vs $5,539; p < .001), compared to $5,984 among patients with diabetes ($19,536 vs $13,589; p < .001). In the psoriasis group, diabetes presented a 13-15% higher incremental total health care costs compared to the psoriasis patients without diabetes ($19,536 vs $10,017; p < .001). This was $1,460 more than the adjusted incremental costs from diabetes among the psoriasis population, diabetes presented a $8,337 adjusted incremental cost compared to $5,984 among patients with diabetes ($19,536 vs $13,589; p < .001), representing an interaction of psoriasis and diabetes conditions, which significantly increases the health care costs.