The Norwegian Prescription Database (NorPD) contains data on all prescriptions dispensed from January 1, 2007, and has a new PPI prescription dispensed for each patient. The overall figure was 25%. For patients starting on PPI treatment during the last quarter before the introduction, to 26%, 24%, 22% and 20% during the four quarters after introduction. The new reimbursement policy for PPIs and its significant changes in the pattern of prescription dispensed. The policy was easier to implement for new patients starting on PPI treatment compared to a compulsory shift for patients on ongoing esomeprazole treatment.

RISK OF UPPER GASTROINTESTINAL ADVERSE EVENTS AND THE EFFECT OF ACID-SUPPRESSIVE THERAPY IN PATIENTS RECEIVING ACETYLSALICYLIC ACID FOR CARDIOVASCULAR RISK MANAGEMENT

OBJECTIVES: Minimizing the risk of upper GI adverse events (AEs), which is common in patients taking non-steroidal anti-inflammatory drugs (NSAIDs), during the use of acetylsalicylic acid (ASA) for cardiovascular risk management. METHODS: The ARIADNE database was created by AstraZeneca to store safety-related clinical study data. For this analysis, data on elderly patients with mild hypertension were extracted. During the follow-up period (mean 1.7 years), patients received antiplatelet therapy (hydrochlorothiazide plus an angiotensin II receptor antagonist or placebo) and other treatments required for their individual care. Among patients without a history of upper GI AEs (n = 45,59), Cox proportional hazard models were used to estimate the relative risk (RR; adjusted for age, sex, and body mass index) of upper GI AEs associated with concurrent use of LDAS and in relation to when PPI therapy was commenced.

RESULTS: Overall, 1,191 patients (26.2%) received LDAS during the study (with or without concomitant acid-suppressive therapy). There was a trend towards an increased risk of upper GI AEs in current LDAS users (RR, 1.27; 95% confidence interval [CI]: 0.95, 1.71). Within the subgroup using LDAS and PPIs (n = 138, 11.6%); the RR of upper GI AEs was 5.41 (95% CI: 3.43, 8.53) when LDAS therapy was initiated before the start of PPI therapy. Adding LDAS to an existing PPI treatment protected against an increased risk of GI AEs. CONCLUSIONS: These data suggest that the risk of upper GI AEs is high in elderly patients receiving LDAS for CV risk management, and that PPIs confer a protective effect against upper GI AEs in these at-risk individuals.

GASTROINTESTINAL DISORDERS – Cost Studies

BASELINE MEDIAN AND 25TH AND 75TH PERCENTILE CDAI SCORES, AS WELL AS MEAN SEX AND AGE DISTRIBUTIONS FOR THE 189 PATIENTS, WITH ACCENT 1 PATIENTS. RESTORATION NNTS FOR WEEKS 30/26 AND 54/56 WERE 57/51, CALCULATED AS WELL AS MEAN 56-WEK AVERAGE REMISSION RATES. Cost per remission was compared using dosages and assuming complete therapeutic adherence. Adalimumab was indicated in all patients. No significant differences in costs were observed for adalimumab’s indicated dosing equations to 10 injections/56 weeks, in the remission NNTs was 5.62; at 26 weeks, the adalimumab unmatched and matched NNTs were 4.34 and 3.86. At 54 weeks, the adalimumab NNT was 6.80; at 56 weeks the adalimumab unmatched and matched NNTs were 4.12 and 3.72. 56-week average for the ICERs against NNT 5.92, whereas adalimumab’s unmatched and matched averaged NNTs were 4.83 and 4.77. Over 56 weeks, costs per patient were $23,885 for infliximab and $22,159 for adalimumab. Average costs per additional remission were $141,399, $107,028, and $105,698 for infliximab, unmatched adalimumab, and matched adalimumab, respectively. CONCLUSIONS: On matched and unmatched comparisons of data from CHARMS and ACCENT 1, adalimumab had better efficacy and cost profiles than infliximab.

PUBLISHED COST-EFFECTIVENESS RESULTS FOR CHRONIC HEPATITIS B AND C – A COMPARATIVE ANALYSIS

OBJECTIVES: Each year, cost-effectiveness studies are published in the area of Hepatitis B and Hepatitis C that have varying results. The current abstract aims to analyze and compare the cost-effectiveness results for Chronic Hepatitis B and C across the different countries in publication to identify characteristics that can be used across and when analyzing for future studies. METHODS: A systematic literature review of the last five years, English only, was conducted using PubMed. Article titles were reviewed by two independent reviewers in order to create a refined list for analysis. The inclusion criterion for analysis was studies related to medications; publications related to vaccination or prevention programs were not included in the analysis. Data from the finalized list of articles was then extracted. For comparison and analysis purposes, all results were converted to 2008 currency values and then to 2008 US Dollars using the Purchasing Power Parities (PPP) rate published by OECD. Lastly, Incremental Cost Effectiveness Ratios (ICERs) were calculated to compare cost-effectiveness across studies, countries and drugs prescribed could not be made. CONCLUSIONS: Utilizing international cost-effectiveness analyses could facilitate the comparison across results generated by these studies. The use of international cost-effectiveness analyses could also allow information to be obtained about additional products and international experience; however these analyses should not serve as a gold standard in health economics.