# Contributed Poster Presentations

## SESSION I

## ARTHRITIS

### ARTHRITIS—Clinical Outcomes Studies

**RHEUMATOID ARTHRITIS IMPACT OF DISEASE AND DRUG THERAPY**

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**OBJECTIVE:** Rheumatoid arthritis (RA) was not considered a fatal disease, however more recent evidence suggests increased frequency of cerebrovascular events in RA patients, attributable to factors beyond those explained in the general population. The primary purpose of this study is to compare the incidence of new cerebrovascular events in RA versus non-RA patients using retrospective database accounting for traditional cardiovascular (CV) risk factors. **METHODS:** RA patient cohort was identified using ICD-9 diagnosis and prescription drug dispensed codes from the Georgia Medicaid population database from 1999 to 2001. Cerebrovascular events were identified using ICD-9 codes for: acute cardiovascular events; other cardiovascular events; precerebral occlusions; and transischemic attacks (TIAs). A randomized stratified matched case control analysis of RA versus non-RA patients was performed based on age, sex, and race. **RESULTS:** A sample of 11,842 was included in the study (5921 RA and 5921 non-RA): 44% were white, 80% female and 70% were aged 21 to 64 years of age. Unadjusted contingency tables showed the odds of someone having CV, TIA, other CV, and occlusive disease was 1.58, 2.74, 3.00 and 2.46 times more likely for a RA than a non-RA patient, respectively. **CONCLUSION:** The results of this study supports earlier studies (Ricon et al 2001) showing that RA patients were at greater risk of cerebrovascular disease, however, further study is needed to investigate the etiology. This could be beneficial in designing preventative treatment strategies.

**INFLIXIMAB DOSING PATTERNS IN RHEUMATOLOGY PRACTICES**

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**OBJECTIVES:** Infliximab, an antibody that binds to tumor necrosis factor-alpha (TNF-alpha) is indicated for the treatment of rheumatoid arthritis (RA). In August 2001, the prescribing information for infliximab in RA was broadened, allowing both dose titration (3–10 mg/kg) and infusion interval modification (every 4–8 weeks). A retrospective, observational study of infliximab dosing patterns in rheumatology practices was conducted to assess the impact of this label change. **METHODS:** Rheumatology practices with multiple calls to the infliximab Health Connections Hotline were surveyed and participated (n = 40). Each practice identified 3 patients pre-label change (group 1) and 3 patients post-label change (group 2) in a blinded, randomized fashion. Data on demographics, insurance, diagnosis code, prior medication use and infliximab infusion history was collected. **RESULTS:** Of 249 responses, 206 (82.7%) were evaluated and analyzed with no statistical differences between groups 1 (n = 98) and 2 (n = 108). The median infliximab dose in the induction phase and first maintenance dose was 3.0 mg/kg for both groups. By maintenance dose 3, the group 1 median dose remained at 3.0 mg/kg while group 2 showed a nonsignificant increase to 4.0 mg/kg, although both groups reported significant steroid discontinuation. The mean number of vials administered at this time was 3.2 (group 1) and 3.7 (group 2). The majority (> 75%) of patients received £5 mg/kg every 8 weeks by maintenance dose 3. **CONCLUSIONS:** Dose flexibility did not significantly increase infliximab dose or decrease dosing interval in this cohort. The majority of RA patients receive an infliximab dose of £5 mg/kg every 8 weeks with concomitant steroid discontinuation.

### ARTHRITIS—Cost Studies

**ECONOMIC EVALUATION OF SELF-INJECTION VS AMBULATORY CARE OF ANTI-RHEUMATOID BIOLOGICS (ETANERCEPT) IN JAPAN**

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**OBJECTIVE:** To compare economic value of two administration methods (self-injection and ambulatory care) of anti-rheumatoid biologics (etanercept) by application of cost-effectiveness analysis (CEA). **METHODS:** From A societal perspective, we gathered cost data and outcome data. Cost data: 1) direct medical cost: physician visit fee, injection fee, laboratory test fee, and in-house self-injection guidance fee (from health insurance fee schedule), drug costs (hypothetical costs—since etanercept is not approved by Ministry of Health, Labour and Welfare yet); 2) direct non-medical cost: transportation cost. Data were gained from "Rheumatoid tomonokai", RA patients organization in Japan and teaching cost of self-injection. To estimate teaching cost, we conducted a survey to health care provider; AND 3) indirect cost: productivity loss. Outcome data: ACR20 gained from 3rd phase of clinical trial data of etanercept in the Japan and safety issues subject to self-injection, such as delayed finding ADR, accidentally impale needles to other people, and so on. Such data were gained from case report form (CRF). Because we set the time horizon for analysis as 1 year, we did not apply discount rate. We performed sensitivity analyses on 1) incidence of ADR; 2) education cost; 3) frequency of hospital visit; AND 4) productivity loss. **RESULT:** Effectiveness of self-injection care and ambulatory care were considered to be similar. Adverse reaction due to self-injection was not reported. Thus, we conducted cost minimization analysis. Total cost of self-injection group including indirect costs was JPY2,674,758 ($US22,746), which was lower than that of ambulatory care group, JPY3,255,110