over 4-months [mean productivity gain in favor of CRO: US$11 paid work; US$6.54 unpaid work]. Friends/relatives of patients on CRO also spent less time assisting patients [mean productivity gain over 4-months in favor of CRO: US$21 paid work; US$18.5 unpaid work]. Improved pain control was observed in patients treated with CRO compared to short-acting opioids as measured by a) proportion of patients with at least a 20% improvement in WOMAC pain score 62.2% vs. 45.9% (p = 0.0003), b) mean HUI3 utility pain domain score at 4 months (0.53 vs. 0.46), and c) mean QALY gain of 0.0105 vs CRO (p = 0.1673). Mean societal cost/patient over 4 months was US$6792 vs. US$6929 (p = 0.3345) for CRO and short-acting opioids, respectively. CRO was both more effective and less costly than the short-acting opioids. CONCLUSIONS: CRO offers advantages over short-acting opioids in terms of reduced time loss from paid and unpaid work. From the societal perspective, CRO was both more effective (QALYs, utilities gained and % patients improved) and less costly than short-acting opioids. These findings, including the impact of productivity loss and QALYs gained should be factored into decisions about treating OA pain.

PAR4

OSTEOARTHRITIS: CHONDROITIN SULFATE LONG TERM UTILIZATION IS COST-SAVING

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OBJECTIVE: To demonstrate that the long term use of chondroitin sulfate (CS) for patients suffering osteoarthritis (OA) is cost-saving. METHOD: Two groups were compared, patients treated less than 6 consecutive months (short term) with CS and patients treated more than 6 consecutive months with CS during 2001–2002 on the IMS Disease Analyzer database. The mean cost per patient and per month was calculated using the total cost of treatment of the period divided by the number of patients and the mean duration of the period (12 months for the follow up, less or more than 6 months in the treatment period). All the analyses were performed within a French NHS perspective. RESULTS: We obtained two groups of respectively 56,325 and 24,732 patients treated with CS for their OA in the short and long term groups. In the follow up period, 12 months for each group; the mean monthly cost per patient was €91.1 per year and per patient could induce an important saving of €627,427.5 for the French NHS if all treated with CS on a short term were treated on a long term. In the follow up treatment period, patients with short term treatment cost patients with short term treatment cost 36% more in coxibs and 42% more in NSAIDs and 190% more in analgesics (p < 0.05). CONCLUSION: The use of CS in OA is more efficient with long term treatment, it was also safer compared to short term treatment. A long term treatment reduces the length of treatment of each co-prescriptions. The saving of 20 days of coxibs treatments, 3 days of NSAIDs and 14 days of analgesics demonstrated that the long term use of CS confirmed that in real life the efficiency and the safety profile made it a safe approach taking into consideration the high risk profile (Gastro-intestinal, cardiovascular, etc.) of the other OA symptomatic treatments.

PAR5

GASTROINTESTINAL (GI) EVENTS, MEDICATION USE AND HEALTH CARE COSTS FOR NEW USERS OF CYCLOOXYGENASE (COX)-2 INHIBITORS AND NONSELECTION NONSTERoidal ANTI-INFLAMMATORY DRUGS (NSAIDS)

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OBJECTIVE: To evaluate upper GI (UGI) events, use of GI medications, and health care costs among arthritis patients in a managed care setting. METHODS: Commercial claims data for three million health maintenance (HMO) and preferred provider organization (PPO) members in Southeast U.S. were used to identify new users of COX-2s and NSAIDs in 2002. Patients had ≥1 arthritis-related claim followed by an index claim for COX-2 (rofecoxib, valdecoxib or celecoxib) or NSAID (ibuprofen, naproxen, diclofenac, and nabumeton) and were continuously enrolled for ≥1 year pre- and post-index date. Patients dispensed either a COX-2 or NSAID during one year pre-index and patients with claims for both COX-2s and NSAIDs were excluded. Multiple logistic regression was used to model UGI events (ulcers and bleeds) and GI medication use (proton pump inhibitors and H2-antagonists), and a log transform model was used for total health care costs (medical and prescription) at 1 year controlling for age, gender, health status, medication persistence, and baseline utilization. RESULTS: In total, 3449 arthritis patients were included: 47% COX-2 (26% rofecoxib, 15% celecoxib, 7% valdecoxib) and 53% NSAID. Patients in the COX-2 group were significantly older, taking more medications and more persistent, more likely to be female or belong to a PPO, and had more comorbidities, GI events, and higher costs