

patterns, and rates of comorbid conditions that exist in patients treated on each regimen. These estimates can be used to calculate and project cost of therapy for patients suffering from HIV/AIDS.

**TPM5****BURDEN OF BRONCHIAL ASTHMA: FAMILY EXPENSES FOR CHILD'S DISEASE**

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**OBJECTIVES:** The object of the present assay was to analyze the type and amount of expenses for the family with a child suffering from bronchial asthma living in Vladivostok between 1996–1998.

**METHODS:** 500 families with asthmatic children were surveyed retrospectively and anonymously.

**RESULTS:** Direct expenditures for the child's disease were  $10,98 \pm 0,94\%$  of annual income. Pharmacotherapy was the main expense item ( $75,96 \pm 1,2\%$ ). Drug expenses for one child were US\$302,  $86 \pm 10, 4$  in 1996, US\$356,  $72 \pm 19, 8$  in 1997. In 1998 the dollar amount of pharmacotherapy didn't change greatly (US\$344,  $4 \pm 20, 2$ ) but a slump in exchange value of the ruble without an adequate increase of ruble income led to expenses growing as a percentage of family income ( $22, 1 \pm 2, 1\%$ ). Self-control means expenditures appeared in 1997 and by the end of 1998  $19 \pm 2,25\%$  of families had sustained them. Doctor visits and sanatorium and health resort expenses per child were 7–8% of direct expenditures for asthma. Less than 5% of families have the means to buy an air cleaning apparatus and hypoallergic linen. The unit price is US\$100–2100 but annual income of a family with an asthmatic child in Vladivostok in 1997 was US\$3493  $\pm 50, 4$ , in 1998 – US\$2996  $\pm 94, 5$ . Owing to the child's disease one of the parents in a third of families either had to be totally unemployed or take low qualified work that aggravated financial loss. Annually  $12,2 \pm 2,1$  disablement days fall on the family because of asthma.

**CONCLUSIONS:** In order to evaluate a family's real means to follow medical recommendations it's necessary to take into consideration family expenses for asthma. Economic state aggravation in the country in August 1998 led to abrupt reduction or interruption of basic asthma therapy in 37,  $86 \pm 4, 36\%$  families for financial reasons. 82,  $8 \pm 1, 67\%$  of parents find the disease to be a considerable financial burden for the family.

**RANDOMIZED CLINICAL STUDY  
METHODOLOGY ISSUES****COST-EFFECTIVENESS ANALYSIS OF  
BUDESONIDE VERSUS DISODIUM****TPC1****CROMOGLYCATE THERAPY IN CHILDREN  
WITH MODERATE BRONCHIAL ASTHMA**

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**OBJECTIVES:** To investigate the cost-effectiveness of using an increased dose of disodium cromoglycate versus switching to budesonide treatment in those children with moderate asthma whose symptoms can not be controlled with the recommended dose of cromoglycate.

**METHODS:** An open, randomized, parallel group design clinical trial was conducted at 20 study centres. After a 4-week run-in period, 131 children with uncontrolled symptoms were randomized either to the treatment of increased disodium cromoglycate  $4 \times 40$  mg daily or budesonide  $2 \times 200$   $\mu$ g daily for a 12-week treatment period. An intention-to-treat analysis was performed. Efficacy variables were the morning PEF value and the number of symptom free days. The economic analysis was based on a societal perspective. Protocol driven costs were excluded from the analysis. Direct costs were measured as costs of study medication, rescue medication, non-protocol driven visits, and number of days stayed at hospital. Indirect cost measurement was based on time missing from school. A sensitivity analysis was carried out on resource use data to test final cost-effectiveness.

**RESULTS:** The morning PEF value increased more from baseline in the budesonide group (30.8 vs. 10.6;  $p = 0.01$ ). The average number of symptom free days was higher in the budesonide group (65.7 vs. 59.5;  $p = 0.09$ ). The average cost of therapy was lower in the budesonide group (HUF 7844 vs. HUF 16962;  $p < 0.0001$ ). The cost per symptom free day was HUF 119 in the budesonide group and HUF 285 in the cromoglycate group.

**CONCLUSIONS:** Budesonide treatment was the dominant strategy as it lead to both superior clinical outcomes and cost savings.

**TPC2****COST-MINIMIZATION ANALYSIS OF TWO  
TRIPLE REGIMENS FOR THE TREATMENT OF  
HELICOBACTER PYLORI-RELATED PEPTIC  
ULCER DISEASE**

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