condition in terms of disease burden, since it affects young people affecting productivity with a high rate of disability. Hospitalisations are needed in almost 75% of patients and more than 3 times during disease evolution (mean 12 years). Further knowledge about potentially preventable factors associated with severity and disease cost and burden would be of extreme value.

PMH54

INDICATION SPECTRUM OF SNRI APPLIED FOR THE TREATMENT OF DEPRESSION—A PHARMACOEPIDEMIOLOGICAL ANALYSIS OF CLAIMS DATA OF A GERMAN SICKNESS FUND

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OBJECTIVES: In the treatment of depression several antidepressants are applied, mainly TZA, SSRI and SNRI. These substances have a different spectrum of activity and side effects, particularly newer substances are often approved for specific indications. Taking SNRI as an example, it is of interest in how far the indication spectrum is therapeutically utilized by physicians in everyday practice. METHODS: A retrospective cohort study using claims data of a sickness fund, analysed beneficiaries who received at least one SNRI prescription during the observation period from January 1, 2004 until December 31, 2004. ICD-10 Codes from the field of depression, anxiety and panic patients, as well as affective disorders were clustered into diagnosis groups which represented potential fields of indication for SNRI therapy. The distribution of diagnoses groups over the indication spectrum was broken down into health care sectors and represented and analyzed with the help of Venn diagrams.

RESULTS: From 1,478,978 beneficiaries n = 2,481 (0.17%) had at least one prescription of Venlafaxin as the only available SNRI in 2004. A total of 75.7% of them had a depression diagnoses, 39.9% received SSRI for relapse prevention. From n = 2,232 beneficiaries with a depression diagnosis and SNRI prescriptions, A total of 22.8% have been treated due to indications (depression in combination with anxiety) for which only Venlafaxin has been approved. 39.7% have been treated due to an indication (maintenance therapy and relapse prevention of depressive disorders) for which besides Venlafaxin only Sertralin was approved. CONCLUSIONS: One out of four depressive patients treated currently with Venlafaxine could not be treated with SSRIs due to the specific pharmacological profile. Maintaining the full spectrum of pharmacotherapy, in this example Venlafaxine for treating depression, will enable physicians treating patients as adequate as possible to the individual patient's indication. A total of 22.8% have been treated due to indications (maintenance therapy and relapse prevention of depressive disorders) for which besides Venlafaxin only Sertralin was approved. Costs of both switchers and combination patients were higher than those of dose-increased patients (respectively: +US$124, adjusted RR = 1.1, 95% CI = [1.0–1.2]); and +US$1060, adjusted RR = 1.3, 95% CI = [1.2–1.5]).

PMH55

A COMPARISON OF PERSISTENCE AND HEALTH CARE COSTS RELATED TO DIFFERENT TREATMENT STRATEGIES AFTER INITIAL ESCITALOPRAM 10MG IN MAJOR DEPRESSIVE DISORDER

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OBJECTIVES: When patients do not respond to their initial treatment, the physician can increase the initial dose, switch to another treatment or add another treatment. This analysis aims at comparing the different strategies after initiation of escitalopram 10mg in patients treated for Major Depressive Disorder (MDD). METHODS: Adult MDD patients initiated on escitalopram 10mg, who either increased to 20mg (dose-increased patients) or switched to (switchers) or were added another anti-depressant (combination patients), were identified in the PharMetrics US claims database (2003–2006). Patients with early dose increase (before 14 days) were excluded as it was considered as a scheduled dose titration. Patients’ characteristics at treatment initiation and treatment outcomes three months after treatment initiation were compared: treatment persistence or change, health care resource use and associated costs. Multivariate regression analyses were performed to adjust for patient characteristics and baseline resource use. RESULTS: A total of 8811 patients started with escitalopram 10mg of which 51% increased to 20mg, 29% switched and 20% had a combination. Mean time to treatment change was 42 days for dose increase, 36 days for switch (p < 0.001) and 30 days for combination (p < 0.001). Three months after treatment initiation, dose-increased patients had higher 3-month persistence compared with switchers or combination patients, even when considering a time-event interaction. Switchers and combination patients had a higher rate of subsequent/second switch and/or combination (17.7% and 71.1% respectively), compared with dose-increased patients (9.5%). Costs of both switchers and combination patients were higher than those of dose-increased patients (respectively: +US$124, adjusted RR = 1.1, 95% CI = [1.0–1.2]); and +US$1060, adjusted RR = 1.3, 95% CI = [1.2–1.5]).

CONCLUSIONS: Increasing the dose of escitalopram from 10 to 20mg was associated with fewer further changes in treatment and with lower costs than switching or adding another antidepressant. For patients who do not respond well to their initial dose, dose increase should be considered before any other strategy.