points (p = 0.007) lower pain score than non-duloxetine-treated patients among individuals who had any opioid use during the 12-month post-index period. CONCLUSIONS: Among similar VA patients with MDD, patients treated with duloxetine were associated with lower opioid use than those treated with other antidepressants. Among patients with any opioid use over the 12-month post-index period, duloxetine-treated patients had better pain scores than non-duloxetine-treated patients.

ECONOMIC OUTCOMES ASSOCIATED WITH HYDROXYUREA ADHERENCE AMONG PEDIATRIC MEDICATION ENROLLEES WITH SICKLE CELL DISEASE

OBJECTIVES: Although not approved for use in pediatrics, hydroxyurea has been shown to decrease painful vaso-occlusive events and hospitalizations (HU) in children with sickle cell disease (SCD), a genetic hematologic disorder primarily affecting people of African descent. However, few data exist on the use of HU, and adherence to treatment, in real-world settings. This study assessed the extent to which children with SCD are adherent with prescribed HU therapy and the association between HU adherence and economic outcomes in this population in a real-world setting.

METHODS: Insurance claims of North Carolina Medicaid program enrollees (June 1999-August 2008) were analyzed. Inclusion criteria were ≥1 claims with a diagnosis for SCD (ICD-9-CM 280.6, 280.62, 280.63), ≥2 HU prescriptions in the year following HU initiation, ≤58 years old at the time of HU initiation, and continuous Medicaid enrollment for ≥12 months prior to and following HU initiation. Adherence was measured using the medication possession ratio (MPR), with MPR > 0.8 considered adherent. Multivariable models were estimated to assess the association between HU adherence and economic outcomes (e.g., inpatient costs) in the 1st year of HU therapy. RESULTS: A total of 159 subjects (55% female, mean age [SD] 11.3 [4.4] years) met all inclusion criteria. The mean MPR was 0.63, with 41% of subjects adherent. Multivariable models revealed that in the year following HU initiation, adherence was associated with a reduction in all-cause ($3,695, p = 0.0003) and SCD-related ($3,002, p = 0.0001) total, inpatient ($217, p < 0.0001), and outpatient costs (17,103 with Kiovig, 17,078 with Privigen, 6,946 with Flebogamma and 6,6317 with Octagam) more than those treated with HU. CONCLUSIONS: Adherence to HU among pediatric SCD patients may be suboptimal and improving adherence to HU therapy among these patients may reduce the economic burden of the illness.

DIRECT MEDICAL COSTS OF LIQUID INTRAVENOUS IMMUNOGLOBULINS IN CHILDREN, ADOLESCENTS AND ADULTS IN SPAIN

OBJECTIVES: The aim of this study is to determine health care resource utilization and direct medical costs in patients treated with intravenous immunoglobulins (IVIGs) in Spain in 2009. METHODS: A cost-of-illness analyses was performed to estimate direct medical costs of patients treated with IVIGs. Prevalence data was obtained from the Spanish Primary Immunodeficiency Registry; a semi-structured questionnaire was used to collect data on health care resource utilization and target population distribution. Inpatient and outpatient costs were considered from the perspective of the public health care system. Hospital costs considered were ambulatory-, ward-, drug- and administration costs. All costs referred to 2009. In medical practice, IVIG doses depend on a patient’s weight and age. Therefore separate analyses were conducted for children and adolescents vs. adults. RESULTS: Thirty relevant research papers (relating to 13th Euro Abstracts) were included in the analysis. The cohort consisted of 2,700 cases of CD and 4,902 cases of UC. We identified a record linkage procedure among three different regional health databases. Multivariate Poisson regression accounting for over-dispersion was used to summarise the state of knowledge of the economic impact of SLE and to give information to implement an European study on costs of SLE care. METHODS: A systematic review of the literature was undertaken in the ECONLIT, EMBASE, Medline and EMCRR databases for full papers relating to the objectives. Key words included SLE, cost, resource, productivity, absenteeism, employment and work disability. Papers were excluded if they were not in English, French, Spanish, Italian or German language. RESULTS: Thirty relevant research papers (relating to 13th Euro Abstracts) were included. Studies were conducted in Canada, Germany, UK and US and used retrospective and prospective methods. Data were mainly obtained from the hospital care setting over a one-year study period. The main resources reported were physician and emergency visits, as well as inpatient hospital stays (of which SLE flares and infections were the main causes). Annual direct costs (converted to December 2009 Euros) ranged from €2,879 (Canada) to €14,873 (US), with indirect costs of €1,214 (US/UK/Canada, friction method) to €45,668 (US, labour market activity method). Indirect costs accounted for at least 38% of the total costs when both market and non-market work was valued. Higher disease activity was reported as a predictor of higher direct and indirect costs. Greater damage, more flares and neoparitis were also found to predict higher direct costs whilst worse physical and/or mental status predicted higher indirect costs. Only one study focussed on the cost of flares. CONCLUSIONS: SLE represents an important cost in the health care system and workplace. However, there is a lack of data on the cost of SLE flares and little recent European data relating to the cost of SLE care. HGS/GSK funded.

Psoriatic Arthritis in the Veterans Affairs (VA) health system. Duloxetine was not on the VA national drug formulary. METHODS: The electronic medical records from January 2004 to December 2008 were requested from the Veterans Integrated Service Network 16 data warehouse. All patients selected initiated either duloxetine or SOC (tricyclic antidepressants [TCAs], venlafaxine, gabapentin, pregabalin) over the study period, with the first dispense date of the index agent as the index date. All patients must have at least 1 prior DPNP diagnosis (ICD-9-CM: 250.6x or 357.2), but no prior depression (ICD-9-CM: 296.2, 296.3, 300.4, 309.1, 311.0), fibromyalgia (ICD-9-CM: 729.1), or neuromyelitis optica (ICD-9-CM: 729.2) diagnosis. Logistic regressions were used to examine the predictors of initiating duloxetine versus SOC controlling for demographics, comorbidities, prior pain level, and prior SOC or opioid use. RESULTS: The analytical sample included 2675 (2155 duloxetine and 2460 SOC) patients. Prior use of gabapentin (odds ratio [OR] = 13.66, 95% confidence interval [CI]: 9.70–19.24, TCAs (OR = 5.40, 95% CI: 3.73–7.82), or venlafaxine (OR = 3.67, 95% CI: 1.67–8.06) was strongly associated with duloxetine initiation. Patients comorbid with anxiety, cerebrovascular disease, or substance abuse were 1.08 (95% CI: 1.40–3.08), 0.44 (95% CI: 1.01–2.07), and 1.11 (95% CI: 1.10–4.01) times more likely to initiate duloxetine, respectively. Prior opioid users were 1.47 (95% CI: 1.02–2.12) times as likely to initiate duloxetine as those with no prior opioid use. Patients with self-reported severe pain were 1.66 (95% CI: 1.11–2.30) times as likely to initiate duloxetine as those with no reported pain. CONCLUSIONS: DPNP patients in the VA health care system who initiated duloxetine appeared to have prior SOC use, more comorbid conditions, prior substance abuse or opioid use, and higher pain level.

SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) IS COSTLY FOR THE HEALTH CARE SYSTEM AND WORKPLACE: A SYSTEMATIC LITERATURE REVIEW

OBJECTIVES: To summarise the state of knowledge of the economic impact of SLE and to give information to implement an European study on costs of SLE care. METHODS: A systematic review of the literature was undertaken in the ECONLIT, EMBASE, Medline and EMBRR databases for full papers relating to the objectives. Key words included SLE, cost, resource, productivity, absenteeism, employment and work disability. Papers were excluded if they were not in English, French, Spanish, Italian or German language. RESULTS: Thirty relevant research papers (relating to 13th Euro Abstracts) were included. Studies were conducted in Canada, Germany, UK and US and used retrospective and prospective methods. Data were mainly obtained from the hospital care setting over a one-year study period. The main resources reported were physician and emergency visits, as well as inpatient hospital stays (of which SLE flares and infections were the main causes). Annual direct costs (converted to December 2009 Euros) ranged from €2,879 (Canada) to €14,873 (US), with indirect costs of €1,214 (US/UK/Canada, friction method) to €45,668 (US, labour market activity method). Indirect costs accounted for at least 38% of the total costs when both market and non-market work was valued. Higher disease activity was reported as a predictor of higher direct and indirect costs. Greater damage, more flares and neoparitis were also found to predict higher direct costs whilst worse physical and/or mental status predicted higher indirect costs. Only one study focussed on the cost of flares. CONCLUSIONS: SLE represents an important cost in the health care system and workplace. However, there is a lack of data on the cost of SLE flares and little recent European data relating to the cost of SLE care. HGS/GSK funded.

PSY21

THE IMPACT OF COMORBIDITY ON INFANTILE BOWEL DISEASE HEALTH COSTS

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OBJECTIVES: To quantify the direct costs (hospitalizations and prescription drugs) of the caring strategies for the Infantile Bowel Disease (IBD). METHODS: All cases of the major types of IBD, Crohn’s disease (CD) and ulcerative colitis (UC), occurred in Apulia between 2002 and 2006 were in the study. The patients were identified through a record linkage procedure among three different regional health databases. Multivariate Poisson regression accounting for over-dispersion was used to assess the average annual direct costs per person. Results were separated, respectively, for the two diseases, as Incidence Rate Ratios (IRR) with 95% confidence intervals. RESULTS: The cohort consisted of 2,700 cases of CD and 4,902 cases of UC. We estimated the average annual costs per person in patients with CD to be equal to 7,153 Euros for hospitalizations and to €2,107 for prescription drugs. In patients with UC the average annual costs per person was of €6,317 and €2,727 for hospitalizations and prescription drugs, respectively. Surgical to medical DRRs ratio for both diseases was 1.5 and the ATC codes relative to intestinal anti-inflammatory, proton pump inhibition, anti-inflammatory/anti-rheumatic and corticosteroids products, represented the 40% of all prescriptions. Overall, our analyses showed, both for CD and UC, that the Charlson Comorbidity Index (CCI) was the only variable associated with the direct costs (i.e. a significant increase in the costs (p-value < 0.0001) was found according to the severity of the CCI. In particular, it was noted that a worse clinical condition before disease onset (CCI before index date) was predictive of larger costs especially...