of adverse events (NAE); extrapyramidal symptoms (EPS); weight gain (WG); and sexual dysfunction (SD). The transition probabilities amongst health states were estimated from two different meta-analysis of clinical trials and from a retrospective Spanish study. The health care costs associated to each health state were obtained from a published Spanish study. It was used the minimum acquisition cost per pack, at the mean daily dose, for each AA, which is regarded as a relevant efficacy criterion in Hospital Pharmacy Departments. The time horizon applied in the analysis was 12 months, a probabilistic sensitivity analysis was performed for all the variables included in the model. All costs were inflated to 2009 using Spanish Health System pay and prices index. RESULTS: In comparison with OLA, the treatment with ARI generates annual average cost savings per patient of €-688.78 ± 21.69 (CI 95%: -614.52; -729.18). In the most unfavourable scenario for ARI, that in which OLA AA may have a similar rate of sexual dysfunction than that of quetiapine (i.e. the lowest rate amongst AA) the costs savings per patient would be €-270.94 ± 17.11 (CI 95%: -237.20; -303.48). CONCLUSIONS: The results of this analysis show that patients treated with aripiprazole demonstrate lower adverse events costs in comparison to olanzapine. This difference may generate significant cost savings to the Spanish health system in the treatment of patients affected by bipolar disorders. The robustness of the results was tested via a probabilistic sensitivity analysis.

**The Costs of Depression in Switzerland**

Tohnian S1, Dibonawatra M1, Jarbriik K1, Locklear J1

1AstraZeneca R&D Mölndal, Sweden; 2Kantar Health, New York, NY, USA; 3AstraZeneca Pharmaceuticals, Wilmington, DE, USA

OBJECTIVES: To investigate the burden of depression in the Swiss population. The costs for the management of depressive patients will be analyzed for different severity classes of disease, based on the Hamilton depression rating scale, over a period of 12 months following diagnosis. METHODS: A prospective, multicentre, non-interventional study in psychiatrist practices was carried out. Patients who have been diagnosed with depression in the last three years were included. The study population was representative of the adult population in each country. Respondents reporting a diagnosis of GAD were propensity-score matched 1:1 to non-GAD controls on country of residence, sex, and employment status. Data were extracted on GAD management (medical care use, resource utilization (emergency room visits, hospitalizations and health care provider visits) and work productivity (using the Work Productivity and Activity Impairment questionnaire) to calculate direct and indirect costs. Health-related quality of life (HRQoL) was derived using SF-12 mental and physical summary scores and utilities were derived from SF-6D preference scores and used to calculate cost per quality-adjusted life-year (QALY). RESULTS: Of 53,524 respondents, 3,669 were assigned to the GAD group. GAD respondents accrued considerably higher direct (medication and health care resources) plus indirect (work productivity loss) costs (per person/year) versus controls across pooled European countries ($5,308.80 vs $2,441.10; P < 0.0001) and for each country (France $6,083.70 vs $2,896.30; Germany $12,797.00 vs $4,477.80; UK $9,017.70 vs $2,011.20; Italy $15,310.40 vs $8,169.60; Spain $3,015.70 vs $1,954.80; P < 0.0001 vs. controls within each country). Direct costs were driven by hospitalizations and psychiatric/psychiatrist visits. Total costs increased with GAD severity from $6,094.00 for respondents with mild GAD to $7,753.10 for those with severe GAD. HRQoL was significantly poorer for GAD versus non-GAD respondents (P < 0.0001). Cost/QALY increased with GAD severity from $6,795 for mild GAD to $13,256 for severe GAD. CONCLUSIONS: The economic and humanistic burden of illness of GAD across Europe is considerable and increases with the severity of disease.