

PSU4

VENTRAL, UMBILICAL, AND INGUINAL HERNIA: REVIEW OF THE CURRENT LITERATUREDe Jonge P¹, Llyod A¹, Tan R², Narewska J¹, Doyle S³, Nafees B¹¹UBC, UK, UK, ²Ethicon, Livingston, UK, ³United Biosource Corporation, London, London, UK

OBJECTIVES: To provide a comprehensive overview of existing literature on inguinal, ventral, and umbilical hernias in the UK, US, France, Germany, and Italy in four independent areas: 1) epidemiology; 2) treatment guidelines and management; 3) health-related quality of life; and 4) economic burden. **METHODS:** Systematic reviews and meta-analyses were reviewed ahead of any single studies. Studies included in the systematic reviews were not reviewed independently. Where systematic reviews were not available, the next highest level of evidence was identified. **RESULTS:** Seven studies examining incidence of inguinal (5), ventral (2), and umbilical hernia (0); 17 studies of HRQL in inguinal hernia repair (none in ventral or umbilical hernia repair); 4 systematic reviews and 22 costing studies of inguinal hernia repair (4 ventral hernia costing studies; none for umbilical); and 10 published guidelines on inguinal hernia repair only (none for France, Italy, or Germany) were identified. No prevalence studies were found and incidence data was limited to hernia repair procedures and recurrences versus true incidence of hernia. Open mesh repair appears most common due to safety, ease of technique, low recurrence rates and cost although laparoscopic repair has potential benefits over open mesh. Hernia repair generally leads to improved HRQL regardless of surgical technique. Mixed evidence supports LH patients having better HRQL, post-operative pain outcomes, return to work and usual daily activities profile following inguinal hernia surgery than OH patients. The inclusion of indirect costs such as absenteeism and presenteeism can significantly reduce or eliminate cost differences between laparoscopic and open repair as noted in TEP procedures. **CONCLUSIONS:** Although hernia repair is a common procedure, its epidemiology, treatment guidelines and management recommendations are not well referenced in the literature. Evidence based decision-making would be improved through reporting of real world, observational, longitudinal hernia repair data.

POSTER SESSION III

ALLERGY-ASTHMA

PAA1

CLINICAL EFFECTIVENESS OF ADJUSTABLE DOSING SINGLE INHALER BUDESONIDE/FORMOTEROL FOR ASTHMA AND BUDGET IMPACT ANALYSIS

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OBJECTIVES: To compare budesonide/formoterol in single inhaler with budesonide + formoterol from separate inhalers and adjustable dosing of single inhaler budesonide/formoterol with fixed dosing in patients with moderate and severe persistent asthma. To assess national payers budget impact. **METHODS:** The clinical effectiveness analysis was performed according to Cochrane Collaboration Guidelines. Budget impact model consist of 3 refund settings scenarios for single inhaler, adjustable dosing budesonide/formoterol. **RESULTS:** Budesonide/formoterol in single inhaler vs budesonide + formoterol from separate inhalers Three RTC were included. No significant difference in quality of life and others parameters of disease symptoms control. Only dysphonia presence was statistically lower in single

inhaler group (I 3 months follow-up), OR = 0.12 (0.02; 0.88). Fixed dosing versus adjustable dosing 7 RTC were included. No significant difference in quality of life and number of patients with at least one disease exacerbation (three months follow-up). Metaanalysis of trials with 5–6 months follow-up showed lower disease exacerbation risk with adjustable dosing, RR = 0.56 (0.40; 0.77). No significant difference in frequency of severe disease exacerbation, multiple exacerbation of disease, necessity of oral administration of corticosteroids and additional therapy. Lower risk of hospitalization/emergency treatment with adjustable dosing, RR = 0.65 (0.43; 0.98) was observed. Both treatments were well tolerated but the adverse event profile was statistically lower in adjustable dosing—less severe, asthma related adverse events, OR = 0.12 (0.02; 0.72) in three months follow-up was noticed. Budget impact model Single inhaler budesonide/formoterol refund consequences per year: 0.4 million sold drug units; 3248 avoided medical visits; 518 avoided hospital/emergency asthma exacerbations treatments; 27.7% reduction in drugs intake volumen; 11–32 millions PLN national insurer budget savings. **CONCLUSIONS:** Single inhaler budesonide/formoterol therapy, especially adjustable dosing, is a clinically effective and well-tolerated treatment for patients with asthma. Refund of this therapy may generate savings for national insurer budget.

PAA2

EFFECT OF SUBLINGUAL IMMUNOTHERAPY (SLIT) ON DIRECT MEDICAL COSTS FOR PATIENTS WITH ALLERGIC RHINITIS AND ASTHMA: RESULTS FROM THE SIMAP DATABASE STUDYBerto P¹, Bassi M², Cadario G³, Cantarutti L⁴, Contiguglia R⁵, Crivellaro M⁶, Di Gioacchino M⁷, Frati F⁸, Magazzù C⁵, Marengo F³, Scamarcia A⁴, Schiappoli M⁶, Valle C⁹, Verna N⁷, Giaquinto C¹⁰¹Pbe consulting, Verona, Italy, ²Rho Hospital, Cerchiate di Pero (MI), Italy, ³Azienda Ospedaliera S.Giovanni Battista di Torino (Molinette), Torino, Italy, ⁴SOSEPE, Padova, Italy, ⁵AUSL 5, Messina, Italy, ⁶Azienda Ospedaliera Verona, Verona, Italy, ⁷D'Annunzio University, Chieti, Italy, ⁸Stallergenes Italy, Milano, Italy, ⁹Ospedale San Paolo, Milano, Italy, ¹⁰University of Padova, Padova, Veneto, Italy

OBJECTIVES: Efficacy of sublingual-immunotherapy (SLIT) has been assessed by several studies and confirmed by the WHO ARIA paper and Cochrane review. Effect of SLIT on consumption of medical resources is yet to be proven in a naturalistic environment. **METHODS:** A network of specialist allergy centres provided data on access to medical care for patients affected by allergic rhinitis (R) with or without asthma (A) enrolled in February 2004. Patients affected by grass pollen allergy, documented by allergen tests, were included in this analysis and split into SLIT patients and patients treated with symptomatic drugs (controls). Outcome measures included use of medications, SLIT, routine care visits, other specialist visits, hospital admissions and tests. Costs were assessed from the perspective of the Italian NHS; unit costs were obtained from published sources (national tariffs for visits and tests; market prices for drugs and immunotherapies). Average cost/patient for the first year after enrolment was produced. **RESULTS:** One-hundred and two patients were analyzed (SLIT/Controls 54/48; M/F 56/46; mean age 30 + 13 years; mean follow-up 376 + 29 days). Demographics were comparable in the two groups. Overall per patient yearly cost of treatment was higher in SLIT patients, in the whole sample (€311 vs. €180/patient), in the R (€288 vs. €116) and R + A (€362 vs. €230) subpopulations, with R + A patients generating more costs than R patients in both groups. Nevertheless considerable savings were obtained in the