PGI10 STRENGTHS AND WEAKNESSES OF CURRENT CLINICAL AND ECONOMIC EVIDENCE FOR THE COMPARISON OF LAPAROSCOPIC VERSUS OPEN REPAIR OF INCISICAL HERNIA
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OBJECTIVES: Incisional hernias are common following abdominal surgery and place a significant burden on patients and healthcare resources. There are two main approaches to mesh-based surgical repair of an incisical hernia: open surgery and laparoscopic surgery. To date, however, no consensus has been reached as to which approach is preferred. The aim of this study was to review the strengths and weaknesses of current clinical and economic evidence comparing laparoscopic with open repair of incisical hernias.
METHODS: Studies investigating clinical and economic outcomes of laparoscopic and open incisical hernia repair published between 2003–2014 were identified. Due to the paucity of available data, evidence is supplemented using findings from large database studies. Other types of study were considered for specific outcomes only when no other evidence was available.
RESULTS: Overall, there is a relatively large body of consistent evidence to conclude that laparoscopic repair of incisical hernia is at least equal to open repair in terms of mortality. Furthermore, compared to open repair, laparoscopic repair is associated with fewer complications, quicker return of life with a possibly longer operative time. In addition, laparoscopic repair of incisical hernia has consistently been shown to be associated with fewer infections and a shorter length of hospital stay. As a result, laparoscopic repair is generally associated with lower costs. However, a meta-analysis of studies comparing laparoscopic with open repair of incisical hernias is limited, there is consistent evidence from studies that compared the costs for both laparoscopic and open repair of incisical/ventral hernia to suggest that the higher operational costs associated with laparoscopic repair, which have been attributed, variously, to a longer operative time or need for more expensive equipment. Further, several studies appear to be offset by the shorter hospital stay associated with the procedure.
CONCLUSIONS: There is consistent evidence to suggest that laparoscopic repair is associated with lower rates of infection and shorter hospital stays (and consequently lower overall costs) than open surgery.

PGI11 PHARMACOECONOMICAL ANALYSIS OF DIFFERENT STRATEGIES OF REPLACEMENT THERAPY IN RUSSIAN PATIENTS WITH PANCREATIC EXOCRINE INSUFFICIENCY
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OBJECTIVES: To perform comparative pharmacoeconomic study of the application of IV generation of pancreatic drugs in patients with pancreatic exocrine insufficiency on the hospital stage of medical care. METHODS: A pharmacoeconomic model of administration of IV generation of pancreatic drugs (creon and ermital) to adult (1000 persons in 14 main groups) during the year of treatment of pancreatic functional insufficiency was developed. Dosage of the drugs was at least 100 units of lipolytic activity per 24 h. Time horizon was 21 days. Measured outcome was clinical efficiency of the applied therapy and the numerical patients who would reach the criteria of treatment success on the basis of the main criteria and “diarrhea relief” and “diabetes relief” parameters. RESULTS: In the modeled conditions, costs of drug therapy per patient were within the range of 962.78 – 1,869.56 RUB in the group of creon and 736.12 – 1,927.38 in the group of ermital. Time horizon was 21 days. CONCLUSIONS: The conducted clinical and economical research demonstrated pharmacoeconomic advantages of enteral administration. It should be noted that the results of this work were significantly influenced by the applied dosages of medications, which were one of the key factors of economical substantiation of use of the considered medical technologies.

PGI12 ECONOMIC BURDEN AND QUALITY OF LIFE OF MODERATE-TO-SEVERE IRRITABLE BOWEL SYNDROME WITH CONSTIPATION (IBS-C) IN GERMANY: RESULTS FROM THE IBS-C STUDY
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OBJECTIVES: To assess the socio-economic burden of moderate-to-severe IBS-C in six European countries: Germany, Italy, Spain, Sweden and UK. METHODS: To assess the economic and quality of life (QoL) results from Germany. METHODS: Observational, retrospective-prospective (6 months each study) of patients diagnosed in the IBS-C (Rome III criteria) and with moderate-to-severe disease at inclusion (IBS-Symptom Severity Scale [IBS-SSS] score ≥ 17). The primary objective was to determine annual direct and indirect costs. Secondary objectives included assessing QoL, at baseline: IBS-QoL and EuroQol-5D (EQ-5D) questionnaire. The productivity loss was assessed using the Work Productivity and Activity Impairment IBS-C questionnaire (WPAI-IBS-C). RESULTS: 102 patients were included from Germany: mean (±SD) age 47.6±18.1 years, 83.3% female, 43.1% severe (IBS-SSS). In the week prior with WPAI-IBS-C completed, the mean WPAI-IBS-C was 35.6±22.3% of time, absenteeism: 14.7±28.2%; work productivity loss: 44.1±32.7%; daily activity

PGI13 COSTS OF INFLAMMATORY BOWEL DISEASE (CROHNS DISEASE AND ULCERATIVE COLITIS) IN SERBIA
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OBJECTIVES: Ulcerative colitis and Crohn’s disease, have a significant impact on health care budget. The aim of this study was to estimate costs of treatment and utilization of resources by patients with inflammatory bowel disease (IBD) in Serbia for 1 year. METHODS: We performed a population-based, cost of illness study to identify direct, indirect and out of pocket costs of treatment of patients with IBD from societal perspective. Patients with Crohn’s disease (n = 59) and patients with ulcerative colitis (n = 50) were enrolled, and patients were followed for the whole year of 2013. The Medical Research Centre surveyed health resource and illness-related expenditures. All costs were calculated in Republic of Serbia dinars (RSD), at one-year level. RESULTS: Total direct costs per patient-year: Although with Crohn’s disease’s were 1,602.97 Euro (192,614,32 RSD) and total indirect costs per patient-year in group with Crohn’s disease were 233,13 Euro (28,014,00 RSD). Total direct costs per patient-year in ulcerative group were estimated on 1,833,97 Euro (142,267,15 RSD) and total indirect costs per patient-year in group with ulcerative colitis were 47,895,00 Euro (3,425,47 RSD). The greatest part of direct costs were incurred by hospitalization (52,350,00 RSD per patient-year for Crohn’s disease, and 47,895,00 RSD for ulcerative colitis), due to prolonged stay in a hospital (31 days per patient-year for Crohn’s disease, and 34 days for ulcerative colitis). CONCLUSIONS: Costs of IBD in Serbia are lower than in developed countries for two reasons: relatively expensive biologic therapy is under-utilized, and prices of health services largely used by the IBD patients are controlled by state on a very low level.
OBJECTIVES: To determine the force of research on economic burden in gastro-
trointestinal disease. RESULTS: From 2010 to 2014, 352 studies published in databases searched for a term “economic burden” and identified 1,870 articles published in 2014, with 968 meeting the inclusion criteria for any disease. Of these, 88 (9%) were in gastrointestinal disorders, based on ICD-10 classifications. Almost half (41 articles) were observational studies, 32 were RCTs or comparative studies, 11 were economic evaluations and 6 were literature reviews. Economic studies were relevant to surgical procedures for colorectal cancer (13 articles); gallstones or cholecystitis (11), appendicitis (7) or hernia repair (7), with 12 articles discussing drug costs. Only 68 studies used cost data associated with medical treatment, mainly for inflammatory bowel disease (6 articles) or peptic ulcer (2). The USA was the most common setting, based on abstract text or author affiliations (27 articles), followed by the UK (6), Italy and Canada (5 articles each). The cost data was reported in 9 articles, of which 3 reported productivity losses. No abstract reported caregiver or social costs. Direct costs were evaluated in 60 articles and healthcare resource use in 69 articles. CONCLUSIONS: Recent research on economic burden in gastrointestinal disorders has focused disproportionately on direct costs and resource use associated with surgical procedures. Up-to-date data on indirect costs, and direct costs of non-surgical interventions, remains sparse.

PG116  PERSISTENCE OF REMISSION AMONG PATIENTS WITH INFLAMMATORY BOWEL DISEASE AFTER ADA'LUMAB RAP THERAPY IS STOPPED: ECONOMIC IMPLICATIONS
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OBJECTIVES: To study the persistence and economic impact of Adalimumab (ADA) discontinuation in inflammatory bowel disease (IBD) patients with at least 6 months in Sustained Clinical Remission (SCR). METHODS: We conducted a prospective observational and retrospective study to assess the persistence and economic impact of ADA discontinuation treatment after achieving SCR in IBD patients between Jan2009-May 2015. Eligible IBD patients were >18 years in SCR on ADA maintenance treatment of 40 mg/14days for a minimum of 6 months. We collected age, sex, indication, persistence (years) of ADA treatment, ADA discontinuation period (years) and if there was an IB relapse after the ADA discontinuation. We determined the real cost of ADA treatment for each patient from individual drug dispensations across the period. The cost savings obtained during the patients ADA discontinuation was calculated using the ADA cost per day for each patient by the days of each patient in complete remission. RESULTS: From Jan 2010 to May 2015, 18 patients (83% women, age 39±10 years, 15 Crohn Disease and 3 Ulcerative Colitis) discontinued ADA therapy. These patients were on ADA therapy for 2.1±1.2 years towards achieve SCR and stopped ADA therapy. The persistence of these patients in SCR (discontinued ADA treatment) was 2.1±1.8 years. 6 patients (33%) relapsed during the period. The cost savings obtained during the patients ADA discontinuation was calculated using the ADA cost per day for each patient by the days of each patient in complete remission.

PG117  EVALUATION OF COST OF MANAGING HEPATITIS C IN GREECE ACROSS ALL DISEASE STAGES AND THE POTENTIAL VALUE OF SIMOFREVIR TRIPLE REGIME AS A TREATMENT OPTION IN THE EARLY STAGES
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OBJECTIVES: To map resource use and associated costs of managing chronic hepatitis C (CHC) in Greece across all disease stages and discuss simofrevir (SMV) in combination with pegylated-interferon a 2b + ribavirin (RB) as a potential treatment option in the early stages. METHODS: An expert panel of 8 leading hepatologists determined local resource use for CHC. Unit costs were obtained from officially published sources. Direct costs (medical, hospital, lab and imaging tests, and pharmaceutical care excluding anti-viral treatment) were estimated for each of the following health states of the disease: non-cirrhotic CHC, compensated cirrhosis, decompensated cirrhosis, hepatocellular carcinoma (HCC) and liver transplantation. Productivity losses were also included in the analysis. The perspective was that of the Social Insurance Fund (SIF) and the cost base year was 2014. RESULTS: The costs associated with non-cirrhotic CHC and compensated cirrhosis were estimated at €94.65 and €228.85, respectively, considering simofrevir tests. Combining simofrevir with pegylated-interferon a 2b + ribavirin for all stages is performed through public hospital outpatient unitstions, without entailing costs for SIFs. The annual per patient costs for decompensated cirrhosis, HCC and liver transplantation were estimated at €170.20, €925.12 and €1,732.87, respectively, and consisted mainly of hospitalization costs. Indirect costs were estimated at €3,009 for both non-cirrhotic and compensated cirrhosis stages, and at €4,539 for decompensated cirrhosis. CONCLUSIONS: Costs of managing CHC increase dramatically with disease stage. Simofrevir combination treatment with pegylated-interferon a 2b + ribavirin could be a cost-effective treatment option for treating patients earlier to prevent high costs at later stages.

PG118  THE COST-EFFECTIVENESS OF REFERRING PATIENTS WITH IRRITABLE BOWEL SYNDROME TO A GASTROENTEROLOGIST IN THE UK
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OBJECTIVES: To explore the financial burden of IBD patients when referred to a gastroenterologist. METHODS: A decision analysis model was conducted to determine the ICER of referring IBD patients to a gastroenterologist in the UK. The model included both direct and indirect costs. RESULTS: Referring IBS patients to the gastroenterologist was associated with an increase in the ICER of £21767.08/QALY. Likelihood of cost-effectiveness at a threshold of £20,000/QALY was 64% for the base case and 58% for different sceneries. A sensitivity analysis revealed that the model was most sensitive to the cost of each healthcare sector. CONCLUSIONS: While referring IBS patients to a gastroenterologist is associated with a considerable ICER, the cost-effectiveness of this decision is uncertain and must be further explored in a multi-centre RCT.