and cost comparisons, with alpha = 0.05. Multivariate regression analyses adjusted for potential cofactors influencing descriptive analyses: logistic for mortality, negative binomial for LOS, and log-linear for costs. RESULTS: Severity of illness was severe/extreme for 60.2% of 2,989,776 projected hyponatremia patients compared to 39.7% of 2,994,724 matched non-hyponatremia patients. Mortality among hyponatremia patients was greater than among non-hyponatremia patients (6.8% versus 5.6%; p < 0.0001). On average, hyponatremia was associated with 2.6 more hospital days (8.5 ± 10.5 versus 5.9 ± 7.7) and 1.5 more ICU days (6.1 ± 8.5 versus 4.6 ± 6.7) than non-hyponatremia (both p < 0.0001). Average total hospital costs were $3254 greater for hyponatremia patients than non-hyponatremia patients ($14,317 ± 23,251 versus $11,064 ± 18,325; p < 0.0001). Multivariate analyses confirmed greater mortality (Odds ratio 1.03, p < 0.0001) and LOS among patients with hyponatremia (p < 0.0001). CONCLUSION: Hyponatremia is associated with greater severity of illness and risk of mortality, longer LOS, and greater hospital costs. Correcting hyponatremia may be important in improving these outcomes.

**PSY32**

**COST-UTILITY STUDY OF RECOMBINANT FACTOR VIII IN THE TREATMENT OF HEMOPHILIA A IN MEXICO**

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OBJECTIVE: To determine the Hemophilia A (HA) treatment (pdFVIII or rFVIII) with the lowest cost per quality-adjusted life-year (QALY) in Mexico. METHODS: A cost-utility study was conducted, with an institutional perspective, in two time horizons, 30 and 50 years. The discounting rate was three percent for costs and benefits. The source of information was a meta-analysis of the international literature validated by Mexican hematologists using the Delphi technique. A decision tree with a Bayesian approach and a Markov chain considering the probabilities of getting infected with Hepatitis C Virus (HCV) and Immunodeficiency Virus (HIV) because of the use of a Factor VIII concentrate and the availability of the products were performed, we also included the probabilities of HCV and HIV infections due to the use of cryoprecipitates because of the lack of the treatments analysed. The model included the states of health: HA without infection, HA+HCV, HA+HIV, HA+HIV-HCV and death. Due to lack of published information and low incidence observed, the probability of getting infected with an emergent disease (Creutzfeld-Jakob, SARS) due to the use of FVIII treatment was not included. The results were evaluated with incremental analysis and net benefits varying the incidence of HIV and HCV and the availability of the products. The sensitivity analysis was one-way, two-way and probabilistic (acceptability curves and net benefit). RESULTS: Patients using rFVIII get more benefits with the lowest cost per QALY when comparing to pdFVIII treatment (30 years-analysis: rFVIII = 16.45 QALY and USD$50,673/QALY, pdFVIII = 11.05 QALY and USD$51,950/QALY, ICER USD$48,066; 50 years-analysis: rFVIII = 20.79 USD$51,406/QALY, pdFVIII = 12.23 QALY and USD$60,763/QALY, ICER USD$38,042). The sensitivity analysis varying the incidence of HIV and HCV showed the robustness of the base study. CONCLUSION: Recombinant Factor VIII is a cost-effective option in the treatment of patients with hemophilia A in Mexico.

**PSY33**

WITHDRAWN

**PSY34**

**COST-UTILITY ANALYSIS OF SUBCUTANEOUS VERSUS INTRAVENOUS IMMUNOGLOBULIN**

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OBJECTIVE: Immunoglobulin replacement is standard therapy that prevents/controls infectious complications caused by primary immunodeficiency disorders especially common variable immunodeficiency and X-linked agammaglobulinemia. In Canada, the therapy is administered intravenously (IVIg) at hospital, whereas in some European countries it is administered subcutaneously (SCIg) at home and intravenously at home/hospital. Canadian Blood Service is considering establishing SCIg as an alternative to IVIg. Concerns over increasing health care costs raise questions about its cost-effectiveness. The present study is intended to estimate cost effectiveness of SCIg against hospital-IVIg and hypothetical home-IVIg from Canada’s public health care payer perspective. METHODS: A Markov decision-analytical model for hypothetical patients in 12-month therapy was used to estimate the incremental cost-effectiveness ratio (ICER) per quality-adjusted life year (QALY) for SCIg compared with hospital-IVIg and home-IVIg. Serious adverse events, mortality, number and severity of infections were considered. RESULTS: SCIg dominates (greater benefits at lesser costs) hospital-IVIg and produces an incremental cost effectiveness ratio (ICER) of CND$39,500/QALY when compared to home-IVIg. ICER is sensitive to changes in utility of infection, hospital charges, and infusion materials. CONCLUSION: SCIg appears to be the most cost-effective intervention if decision makers are willing to pay CND$39,500/QALY. Therefore, it could be gradually established as an alternative to patients who are willing and clinically suitable to switch. Uncertainty in the available comparative clinical effectiveness warrants a reliable comparative clinical study.

**PSY35**

**PREVALENCE OF METABOLIC SYNDROME AND ITS IMPACT ON HEALTH CARE RESOURCE UTILIZATION**

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OBJECTIVE: To assess the prevalence of metabolic syndrome in five European countries and to quantify its impact on resource utilization. METHODS: Data were from the 2006 European National Health and Wellness Survey (NHWS), a self-administered, Internet-based study of the health care attitudes, behaviors, disease states, and outcomes of a demographically representative sample of adults age 18+ across five European countries: France, Germany, Italy, Spain, and UK. Individuals were categorized with metabolic syndrome if they were diagnosed with diabetes and had two or more of the following: hypertension, high cholesterol, or obesity (BMI ≥ 30). Prevalence estimates were computed using frequency weights based on gender and age distribution of each country as reported in the International Database of the U.S. Census Bureau. Linear regression models were developed using unweighted data to assess the association between metabolic syndrome and resource utilization in the past six months. Covariates included in the models included gender, age, marital status, education, and country of residence (reference=UK). RESULTS: There were 1092 respondents across the five European countries that were categorized as having metabolic syndrome. These respondents project to approximately 6.24 million individuals affected by metabolic syndrome. The prevalence of metabolic syndrome varied across the 5 countries.