lower than those patients with a GFR of improved graft functioning status (increased GFR) at one year. The average maximum of both sites were included in the analysis. The total three-year cost of post-transplant, dyslipidaemia and infections. Immunosuppressant drug costs were not 1

women with OAB in Hungary.  

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KIDNEY TRANSPLANT PATIENTS IN FRANCE  

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OBJECTIVES: Overactive bladder syndrome (OAB) is a urological condition defined by a set of symptoms including urgency, with or without urge incontinence, usually with frequency and nocturia. Our aim was to assess the productivity and costs of women with OAB in Europe. METHOD: Cross-sectional survey was performed in 5 urology/gynecology outpatient centres. Demographic and clinical characteristics were recorded. Medication, health and informal care utilisation were surveyed for the past 12 months. The Work Productivity and Activity Impairment questionnaire (WPAI) was used to assess productivity. Cost calculation was performed from the societal perspective and human capital approach was used. RESULTS: Sixty-six women with mean age of 56.9 (SD=12.4) years participated in the study, 3 (5%) singles, 38 (58%) married, 14 (21%) divorced and 11 (17%) widows. Forty-six (70%) were in menopause and 45 (60%) were overweighted. Patients have had symptoms for 6.6 (SD=2.2) years in average, 62 (94%) had incontinence of whom 41 (66%) experienced incontinence episodes daily and 30 (48%) used incontinence pads. Twenty-six patients (39%) were taking medication for OAB and 22 (33%) had antibiotic treatment due to urinary symptoms in the past year. Patients had diverse diagnostic procedures (e.g. ultrasound: 98%, cystoscopy 49%, uroflow 64%, cystocopy 20%), 10 (15%) were admitted to hospital due to urinary problem. Twenty-three (35%) patients were working and 2 of them were on sick-leave in the past year. With the results of working were decreased productivity 44%, impaired activity 48.2%, this latest was 50.7% for non-workers. Total costs were €340/patient/year (conversion €1=275.4 HUF), rate of direct medical, direct non-medical and indirect cost was 92.6%, 6.8% and 0.6%, respectively. CONCLUSIONS: This study is the first to offer data on productivity and costs of patients with OAB in Hungary. Results suggest that preseensin is a major problem and direct medical costs (diagnostics, drugs) are dominant.  

4-YEAR INCIDENCE AND COSTS OF HOSPITALIZED COMPLICATIONS WITHIN KIDNEY TRANSPLANT PATIENTS IN FRANCE  

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OBJECTIVES: Complications are common following kidney transplantation. The French Hospital National Database (PMSI) allows patients follow-up through their hospitalization reports. This study assessed 4-year incidences of complications after kidney transplantation and estimated their economic impact, in particular renal complications. METHODS: From the years 2006-2010, hospitalization data for all patients with kidney transplantation in year 2006 were extracted. Patients' hospital stays were followed during a period of 4 years. Major hospitalizations of interest were pooled in renal, cardiovascular and infectious complications. Renal complications were, were detailed in acute rejection (AR), recurrence of initial nephropathy (RIN), chirurgical complication and, others. Incremental costs were estimated by subtracting transplantation-year mean cost of patients without any renal complications to the one of those with renal complications the same year. Mean annual costs of patients with graft loss were assessed separately for each year. Costs were calculated according to the 2010 National Hospital Tariff and National Scale. RESULTS: A total of 2392 patients with kidney transplantation in 2006 were identified. A total of 61.5% were males and mean age was 45.0 (±14.9) years. The mean annual costs of cardiovascular and infectious complications were 54.8% (n=1,311), 20.8% (n=498) and 19.8% (n=474). Incidences of AR, RIN, chirurgical complication and, others renal complications were 24.5%, 21.1%, 4.1% and 22.4%, respectively. Comparison to other patients without any renal complication (First-year mean costs: €22,170, Q1=17,341-Q3=27,649), the corresponding incremental costs for renal complications were €7,046, €10,376, €10,238, €7,874 and, €5,668. During the 4-year period, graft loss occurred in 4.4% patients. Annual mean costs of graft loss for the first, second, third and fourth years were €32,159 (Q1=61,723-Q3=84,180) (n=105), €19,085 (Q1=4,729-Q3=20,363), €25,269 (n=52), and, €20,780 (n=41), respectively. CONCLUSIONS: After transplantation, short-term renal complications are frequent and expensive. Intensive interventions on renal preservation and graft loss prevention are needed.  

DIRECT AND INDIRECT COSTS OF URINARY URGENCY INCONTINENCE WITH AND WITHOUT PHARMACOTHERAPY  

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OBJECTIVES: To evaluate the impact of treating urge urinary incontinence (UUI) on health care resource utilization, productivity, activity impairment, and associated costs. METHODS: The study used data (N=75,000) from the 2011 National Health and Wellness Survey, a self-administered, Internet-based questionnaire of a nationwide sample of adults (age ≥18). Respondents with UUI or MUI were identified via a 3 Incontinence Questions. Respondents with stress urinary incontinence only, prostate cancer, or (medication for) benign prostatic hyperplasia, were excluded. UU/MU respondents were categorized as using prescription medication (Rx users) for overactive bladder (OAB) and non-Rx users (who never used Rx and whose condition reportedly interfered with life activities or was difficult to manage). Outcome measures included health care utilization (type/number of resources used within the past 6 months) and Work Productivity and Activity Impairment questions-based scores. Direct and indirect costs were estimated using 2010 labor and 2008 medical expenditure data sources. Generalized linear models predicted resource use and productivity as a function of treatment status, adjusting for covariates (e.g., sociodemographics, BMI, OAB severity, UUI vs. MUI, and comorbidity status) that may also predict impairment. RESULTS: Among 1,790 UU/MU respondents, 505 were defined as Rx users and 1,285 as non-Rx users: Rx users were more likely to be female (80.7% vs. 70.0%), older (mean=62.7 vs. 53.1), non-Hispanic White (82.3% vs. 69.7%), college educated, health-insured (94.6% vs. 81.7%), unemployed/retired (72.6% vs. 57.7%), and reporting more moderate-to-severe OAB (70.9% vs. 62.6%, all p<0.05). Adjusting for covariates, Rx (vs. non-Rx) users had lower work impairment (11% vs. 25%), more provider visits (7.42 vs. 5.60) and lower costs ($18,175 vs. $13,679), and higher total direct costs ($27,291 vs. $21,493), all p<0.01. CONCLUSIONS: UUI patients using, vs. never using, prescription medication reported lower activity impairment but higher direct costs. The findings may inform the degree to which UUI pharmacotherapy affects health outcomes.  

COMPARATIVE COST-ANALYSIS OF SIX ANTICHOLINERGICS FOR THE TREATMENT OF OVERACTIVE BLADDER AND INCONTINENCE IN GERMANY  

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OBJECTIVES: Comparing the costs of Solifenacin, Oxybutynin, Tamsulosin chloride, Tolterodine, Propiverine, and Darifenacine for the treatment of overactive bladder (OAB) and incontinence in Germany. DATA AND METHODS: The cost-study is based on a unique sickness fund dataset of 2.9 million insured persons which included pharmaceutical, outpatient, inpatient, medical aids as well as remedies data in 2009. 25,896 persons received anticholinergics and were classified as OAB patients, 4,152 of these patients also suffered from incontinence. Multiple linear regression models were performed to control for age and gender effects. Further- more, a general approach (all costs were included) as well as a specific approach (only costs associated with OAB were considered) were used. RESULTS: OAB patients caused additional costs of €2,492 using the general and €782 using the specific approach compared to Non-OAB patients. Darifenacine (€1,854) had the lowest additional costs under the general approach and patients treated with Darifenacine (€3,230) the highest. In the specific approach, patients treated with Propiverine (€691) had the lowest additional costs and patients treated with Tolterodine (€1,324) the highest. In the case of incontinence, patients treated with Solifenacin have shown, by far, the lowest additional costs using either approach (€3,216, €1,320). These results are mainly driven by the lower costs
of aids, especially due to the lower pad usage. Patients treated with Trosopium chloride (65,409) exhibited the highest costs using the general approach and patients treated with Teflodon (9,748) incurred the highest costs using the specific approach. All results were highly significant (p<0.01). CONCLUSIONS: This study compares the costs of six anticholinergics for the treatment of OAB and incontinence in Germany. OAB patients treated with Propiverine and incontinence patients treated with Solifenacin exhibited the lowest cost of €0.133 LYG. PSA showed 96.7% probability of tacrolimus OD vs. tacrolimus BD in treatment of post-renal transplant patients in 15 year horizon. METHODS: We developed a Markov cohort model (using TreeAge PRO 2012) with 1 year cycle length with Life-Years-Gained (LYG) as an outcome, the model reflects health insurances’ perspective. We used literature derived time-dependent probabilities of transitions among particular health states (incl. mortality). Patients enter the model after successful kidney transplantation. We identified following health states: Graft survive, Acute graft rejection (AR), Chronic allograft rejection (CAR), deaths. We assessed cost-effectiveness of tacrolimus OD vs. tacrolimus BD in treatment of post-renal transplant patients in 15 year horizon. METHODS: We identified following health states: Graft survive, Acute graft rejection (AR), Chronic allograft rejection (CAR), deaths. We assessed cost-effectiveness of tacrolimus OD vs. tacrolimus BD in treatment of post-renal transplant patients in 15 year horizon. RESULTS: Tacrolimus OD is dominant intervention (lower costs and simultaneously higher outcomes) despite 10% higher acquisition costs compared to BD, other costs of AR and CAR were discounted by 3% rate. We performed One-Way-Sensitivity (OWA) and Probabilistic-Sensitivity (PSA) analyses using 20% deviation from base-case. RESULTS: The model predictability, in term of patients’ survival within 15 year horizon, was validated according to mortality data in several kidney transplant patients’ registries. The deterministic results in 15 year horizon showed that tacrolimus OD generated costs of €67,457€ (10.714 LYG) and tacrolimus BD €68,316€ (10.581 LYG), tacrolimus BD revealed increased mortality costs of 856€ and -0.133 LYG. PSA showed 96.7% probability of tacrolimus OD being dominant intervention (lower costs and simultaneously higher outcomes) despite 10% higher acquisition costs compared to tacrolimus BD. OWA showed that the results were the most sensitive on tacrolimus acquisition cost, compliance rate and cost of dialysis.

P102 COST-EFFECTIVENESS OF IMMUNOSUPPRESSIVE REGIMENS IN RENAL TRANSPLANT RECIPIENTS IN GERMANY: A MODEL UPDATE

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OBJECTIVES: Standard of care and use of immunosuppressive drugs in renal transplant recipients have changed in recent years. We provide an updated pharmaco-economic model which reflects the standard of care in immunosuppressive regimens based upon current evidence. To our knowledge this is the first analysis in transplant medicine using a mixed treatment comparison (MTC) analysis. METHODS: An established Markov model was updated comparing four current standard of care immunosuppressive regimens (which reflect real world clinical transplant practice not necessarily restricted to an approved label: Sirolimus + early withdrawal of Ciclosporin + Steroids (TR1), Similansir-early-transi (TR2), Everolimus-early-transi (TR3) and Tacrolimus low dose + Mycophenolate mofetil + Steroids (TR4)). Patients could experience nine different states of post-transplant adverse events, discontinue TR or die. Transition probabilities were based on a MTC analysis for a 12 month time horizon. Costs and benefits were modeled from the perspective of the German statutory health insurance (SHI). Robustness of the model was tested in extensive sensitivity analyses. RESULTS: Sirolimus early transition” (TR2) yields the highest life years (LY) (9.987 LY), while TR1, the regimen used in the European registration study, in terms of ICER (incremental cost-effectiveness ratio) in Euro per LYG gained for 12 months. Incremental costs of 1,069€ for TR2 in comparison to TR4 resulted in an ICER of 548,000€ per QALY gained. CONCLUSIONS: The early transition to Sirolimus is a cost-effective option compared to the other regimens investigated in terms of patient survival and ICER per life year gained. The analysis corroborates the feasibility of a MTC approach and reflects crucial outcomes which may support informed clinical decision making.

P103 COST-EFFECTIVENESS OF KETOSTERIL TREATMENT IN DIALYSIS PATIENTS

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OBJECTIVES: There are evidences on the favorable nutritional effects of Ketosteril in dialysis. Better quality of life and overall survival is attainable through improved nutritional status, which is also proved in practice. Our aim was to evaluate the cost-effectiveness of Ketosteril in dialysis in comparison with CKD treatment without Ketosteril. A cohort calculation was presented on the basis of representative patient attendance data from the Hungarian National Health Insurance Fund Administration (HNHFIA). Main outcome of the analysis was incremental cost of life years gained (LYG). METHODS: HNHFIA database uniquely contains detailed pre- vision data from the whole Hungarian population of 10 million. All financed health care providers use the same report structure and reported data are strictly validated. Our retrospective analyses included data of 2004-2009 for all dialysed patients with chronic kidney disease (CKD code N17-19) as main diagnosis. Altogether 13 615 patients’ data were included with a mean follow up of 53 months. Ctree function of party package in R statistical program was used to determine empirical survival curves for patients treated with and without Ketosteril. Total costs of healthcare services (in- and outpatient care, lab, diagnostics, drugs, medical aids and sick leave) were taken into consideration. In case of death life years’ loss was calculated on the basis of Hungarian life expectancy. Costs and outcomes were discounted with official Hungarian rate of 5%. RESULTS: The average total per patient costs with Ketosteril were 96 € higher for first year (9.74 vs 8.87 €). A larger proportion of mortality data we determined lost life years, which showed 0.97 years favour to Ketosteril (7.24 years vs 8.21 years). ICER of 3 509 460 HUF/LYG represents cost-effectiveness of Ketosteril compared to other reimbursed health technologies in Hungary. CONCLUSIONS: Ketosteril therapy of dialysis patients could be a cost-effectiveness treatment choice based on real world data analysis of Hungarian patients.

P104 COST-EFFECTIVENESS ANALYSIS OF MIRABEGRON VERSUS TOLTERODINE EXTENDED RELEASE IN THE TREATMENT OF PATIENTS WITH OVERACTIVE BLADDER IN THE UNITED STATES

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OBJECTIVES: The INDEPENDENT study involved 107 (Sev) and 105 (CaC) patients with a 36 months follow-up. Since few of the patients remained dialysis free (76 vs 63). Individual hospitalizations in Nephrology, Cardiology and ICU were recorded as well the overall length of stay over the observation period. Correlated consumption of drugs, such as alpha and beta blockers, ARBs, ACE inhibitors, calcium channels blockers and erythropoietin, was also assessed. For hospitalizations and drugs, DGR tariffs and hospital acquisition cost respectively were used. As effectiveness end-point we considered the number of patients remaining dialysis free (76 vs 63). Individual hospitalizations in Nephrology, Cardiology and ICU were recorded as well the overall length of stay over the observation period. Correlated consumption of drugs, such as alpha and beta blockers, ARBs, ACE inhibitors, calcium channels blockers and erythropoietin, was also assessed. For hospitalizations and drugs, DGR tariffs and hospital acquisition cost respectively were used. As effectiveness end-point we considered the number of patients remaining dialysis free (76 vs 63). Individual hospitalizations in Nephrology, Cardiology and ICU were recorded as well the overall length of stay over the observation period. Correlated consumption of drugs, such as alpha and beta blockers, ARBs, ACE inhibitors, calcium channels blockers and erythropoietin, was also assessed. For hospitalizations and drugs, DGR tariffs and hospital acquisition cost respectively were used. As effectiveness end-point we considered the number of patients remaining dialysis free (76 vs 63). Individual hospitalizations in Nephrology, Cardiology and ICU were recorded as well the overall length of stay over the observation period. Correlated consumption of drugs, such as alpha and beta blockers, ARBs, ACE inhibitors, calcium channels blockers and erythropoietin, was also assessed. For hospitalizations and drugs, DGR tariffs and hospital acquisition cost respectively were used. As effectiveness end-point we considered the number of patients remaining dialysis free (76 vs 63). Individual hospitalizations in Nephrology, Cardiology and ICU were recorded as well the overall length of stay over the observation period. Correlated consumption of drugs, such as alpha and beta blockers, ARBs, ACE inhibitors, calcium channels blockers and erythropoietin, was also assessed. For hospitalizations and drugs, DGR tariffs and hospital acquire...