HAL-treated patients that had responded to therapy at each of the three thresholds defined. Six-week response-curves were compared using log-rank tests.
RESULTS: As the threshold for classifying a patient as a responder increased, the relative divergence between drug-response curves increased with the OLZ treatment group consistently attaining higher proportions of responders than the HAL treatment group. At a minimal threshold for response (≥20%), 77% of OLZ versus 70% of HAL-treated patients responded by week 6 ($p = 0.002$). At a high bar threshold for response (≥65%), 25.9% of OLZ versus 15.6% of HAL-treated patients responded by week 6 ($p < .001$). Furthermore, a separation of response rates in favor of OLZ could be seen as early as week 2.
CONCLUSION: Rigorously as compared to minimally defined thresholds for response clearly differentiate the greater likelihood of patients achieving superior improvement on the novel antipsychotic OLZ as compared to HAL.

PMH2

IMPROVEMENT IN QUALITY OF LIFE AND DEPRESSIVE SYMPTOMS IN SCHIZOPHRENIC PATIENTS IS ASSOCIATED WITH ROBUST ACUTE TREATMENT RESPONSE OF OLANZAPINE VERSUS HALOPERIDOL

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OBJECTIVE: The objective of this analysis was to explore the association of improvement in QoL and depressive symptoms with robust acute treatment response of olanzapine (OLZ) versus haloperidol (HAL).
METHODS: Data was analyzed post-hoc from a double-blind, randomized (OLZ versus HAL), trial of 1996 patients with schizophrenia or a related disorder. The treatment response was classified into four groups based on improvement of the Brief Psychiatric Rating Scale (BPRS) total scores at 6 weeks: <20%, 20–40%, 40–65% and >65% improvement. Mean percent changes of Quality of Life Scale (QLS) scores and Montgomery-Asberg Depression Rating Scale (MADRS) were determined.
RESULTS: There was a significant positive association between the more robust level of response (i.e., >65%) and improvements in depressive symptoms and QLS across treatment groups. Patients treated with OLZ started to access moderate improvement (>10% improvement) in QLS once they attained a 20% or greater improvement in BPRS while for the HAL-treated patients, only those who had a 65% or greater response in BPRS could exceed moderate QLS improvement. The mean percent change in QLS in the 20–40% BPRS response group was 13.4% for OLZ versus 1% for HAL ($p = 0.031$) and in the 65% or greater BPRS response group was 41.8% for OLZ versus 32.8% for HAL ($p = 0.45$). Similar observations were demonstrated in improvement on the MADRS. For patients with a 40–65% BPRS response, the improvement in MADRS was 34.9% for OLZ versus 6.7% for HAL ($p = 0.027$).
CONCLUSION: A more robust categorical acute treatment response resulted in greater improvement in QoL and depressive symptoms across treatment groups. For patients attaining the same level of acute treatment response though, there may be significantly greater improvements in QoL and depressive symptoms enjoyed by OLZ-treated patients compared to those treated with HAL.

PMH3

PATIENT MEDICATION ATTITUDE AFTER SWITCHING TO ZIPRASIDONE FROM OTHER ANTIPSYCHOTICS

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OBJECTIVE: Patients with schizophrenia switched from conventional antipsychotics, olanzapine, or risperidone, to ziprasidone show significant improvements in weight, prolactin levels, and lipid profile. Since such benefits may affect patient behavior and resource use, Drug Attitude Inventory (DAI) was administered to assess attitudes/feelings about antipsychotic therapy.
METHODS: Three six-week multi-center, open-label, parallel-group trials of similar design were undertaken in stable schizophrenic outpatients switched from conventional antipsychotics (n = 108), olanzapine (n = 104), or risperidone (n = 58) because of poor tolerability or insufficient efficacy. Each trial randomized patients to 1 of 3 switch strategies—"slow" taper, "fast" taper, or "abrupt discontinuation" of prior medication before initiating ziprasidone (80 mg/day for 2 days; 40–160 mg/day thereafter). The 10-question true/false DAI was administered at baseline and week six. The primary summary measure was total score (sum of responses to all questions). Data were combined from all switch subsets for each study because there was no significant difference in mean change from baseline to week six among strategies. Positive total score indicated likely compliance, whereas negative total score, likely noncompliance. A categorical linear model was used to analyze marginal probabilities of favorable responses over total, attitudinal, and subjective question sets.
RESULTS: Total DAI scores improved significantly in patients switched to ziprasidone from conventionals ($P = .003$) or risperidone ($P = .008$). Categorical analysis identified significant improvements in patients switched to ziprasidone from conventionals ($P = .05$ all items, $P = .02$ subjective) and a trend toward improved scores in those switched from olanzapine ($P = .06$ for both). DAI improvement from baseline to week six was consistently driven by positive change in subjective feelings. Ziprasidone was safe, well-tolerated, and effective, regardless of dose or switch strategy.

CONCLUSIONS: Schizophrenic outpatients report better subjective feelings about medication use after switching to ziprasidone. These findings have implications for greater patient compliance with ziprasidone and, possibly, for decreased relapse rates and health-care resource use.

PMH4

DRUG SELECTION, DOSING, AND UTILIZATION PATTERNS AMONG DEPRESSED PATIENTS TREATED WITH SSRI'S AND VENLAFAXINE IN US MANAGED CARE PLANS

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OBJECTIVE: The purpose of this analysis was to describe and compare patterns of drug selection, dosing, and utilization among depressed patients treated with SSRIs (citalopram, fluoxetine, paroxetine, and sertraline) and venlafaxine in US managed care.
METHODS: Symmetry Health Data Systems' Episode Treatment Group methodology was applied to PharMetrics' Integrated Outcomes Database to identify adult subjects (>18 years.) diagnosed with depressive disorder and treated with one of the study medications between January 1, 1998 and June 30, 1999. Prescription claims records were used to identify patterns of drug selection, dosing, and utilization (medication persistence, augmentation, switching, and time to change) for each medication cohort. Descriptive statistics were used to characterize drug selection and dosing patterns, and parametric and nonparametric methods (ANOVA and chi-square) were used to compare utilization indicators across study groups.
RESULTS: Twelve thousand twenty six patients met inclusion criteria. The study cohorts were demographically similar. Index antidepressant drug prescriptions were for citalopram (6.2%), fluoxetine (24.6%), paroxetine (29.5%), sertraline (33.4%), and venlafaxine (6.2%). Citalopram patients more often started (86.7%) and ended (78.4%) on the lowest available dose. Each cohort showed similar patterns of dosage titration/adjustment. The mean number of prescriptions was similar across cohorts; citalopram-treated patients had a significantly higher rate of persistence (mean = 118.3 days) than those treated with paroxetine (106.5), sertraline (108.8), and venlafaxine (108.2) cohorts ($p < .001$). Augmentation and switching rates were similar across cohorts; citalopram patients whose therapy changed had a significantly longer time to change (mean = 80.9 days) than fluoxetine (76.8 days, $p = 0.02$), paroxetine (72.1 days, $p < .001$), sertraline (69.6 days, $p < .001$), or venlafaxine (66.8 days, $p < .001$) patients.
CONCLUSIONS: Of the antidepressants evaluated, citalopram was most frequently prescribed at the lowest available dose. Persistence rates were also highest with citalopram. Clinicians and payers should consider differences in dosing and persistence to provide optimal care and benefits for depressed patients.

PMH5

THE COST-EFFECTIVENESS OF QUETIAPINE IN THE TREATMENT OF SCHIZOPHRENIC PATIENTS PARTIALLY RESPONSIVE TO PREVIOUS ANTIPSYCHOTICS—AN ECONOMIC ANALYSIS OF THE PRIZE STUDY

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OBJECTIVE: Psychiatrists often see patients who show only a partial response to conventional antipsychotics. This study assessed the cost-effectiveness and economic impact of quetiapine treatment in this clinically important patient population.
METHODS: A decision-analytic model with Markov processes was constructed to assess the costs and health benefits of quetiapine and haloperidol treatment over a five-year period in a UK National Health Service (NHS) setting. Response to medication and incidence of extra pyramidal symptoms (EPS), were derived from a prospective, double blind, randomized clinical trial, the PRIZE study. Transition probabilities used in the model were derived from a thorough review of the literature and expert opinion. Resource use unit costs were taken from the literature. Discount rates of 6% were applied to costs and 1.5% to outcomes as recommended in the UK by the National Institute of Clinical Excellence.
RESULTS: This model found the overall cost of quetiapine treatment per patient to be comparable with the cost of treatment with haloperidol over a five-year period (£37,379 quetiapine versus £37,596 haloperidol). Hospitalization and institutionalization costs were £1,911 less with quetiapine. Outpatient cost savings was estimated at £642 with quetiapine per five years. Over the five-year course of the model, the short-term clinical benefits shown in the PRIZE study lead to quetiapine-treated patients experiencing fewer relapses and responding to treatment for a longer time compared to haloperidol-treated patients. Sensitivity analyses showed the results to be robust to testing of key assumptions.
CONCLUSIONS: With better outcomes and similar treatment costs to haloperidol, quetiapine represents a cost-effective treatment for schizophrenia in patients who show only a partial response to conventional antipsychotics.

PMH6

PATTERNS OF COMORBIDITIES AND COPRESCRIBING AMONG DEPRESSED PATIENTS TREATED WITH SSRI'S AND VENLAFAXINE IN US MANAGED CARE PLANS

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OBJECTIVE: The purpose of this analysis was to describe and compare patterns of comorbidities and coprescribing among depressed patients treated with SSRIs