information, brinzolamide is more efficient than brimonidine in the treatment of glaucoma patients, in mono-therapy, in all treatment lines. Patients remained treated longer with brinzolamide.

PEY5

COMPARISON OF PHYSICIAN AND PATIENT-REPORTED OUTCOMES OF ADULTS WITH DRY EYE DISEASE (KERATOCONJUNCTIVITIS SICCA) MANAGED OVER TIME IN A PATIENT REGISTRY

Steeds CS1, Buchholz P2, Irwin DE3, Figueiredo FC4, Figueiredo MS4

1CS Consulting, Motherwell, Scotland, UK, 2Allergan Europe, Ettlingen, Germany, 3University of North Carolina, Chapel Hill, NC, USA, 4Royal Victoria Infirmary, Tyne and Wear, UK

OBJECTIVE: To compare physician and patient rating of dry eye disease severity over time, with standard clinical tests and a QoL measure within a patient registry. METHODS: Patients with moderate to severe dry eye disease, who were attending the dry eye clinic at the Royal Victoria Infirmary in Newcastle, UK, and consented to participate in a patient registry, were recruited. Patients were managed as in routine clinical practice. Patients and physicians rated disease severity at baseline and over time on a scale of 0–9 (0 Normal, 1–3 Mild, 4–6 Moderate, 7–9 Severe). In addition, a range of standard clinical tests for dry eye and a validated, quality of life instrument (Ocular Surface Disease Index—OSDI®) were completed. RESULTS: Data from 75 patients were analysed, 91% were white females and 84% were postmenopausal. Fifty-nine percent of patients had at least 4 follow up visits (mean time approx. 16 months). At baseline, 46% of patients rated their dry eye disease as moderate and 43% as severe, compared to 62% as moderate and 36% as severe by the physician. From baseline to visit 4, the change in disease severity by category was 38% improved, 41% same and 21% deteriorated by the patient's assessment. In comparison, by the physician's assessment, 49% of patients improved, 49% stayed the same and 2% deteriorated. The patient's rating of their disease correlated well with the OSDI® (Spearman correlation coefficient; 0.53, p < 0.001). The physician's rating of disease status correlated well with 2 of the standard clinical tests for dry eye (Oxford staining; 0.50, p < 0.001 and Tear Function Index; 0.43, p < 0.001). CONCLUSIONS: Patients tend to rate their dry eye disease as more severe than the physician. It is important to include patient-reported outcomes as part of the assessment of dry eye disease severity and the management of patients.

PEY6

POSTERIOR CAPSULAR OPACIFICATION AND ND: YAG LASER TREATMENT AFTER CATARACT SURGERY IN FRANCE: COMPARISON ACCORDING TO INTRAOCULAR LENS WITH SQUARE EDGED OPTIC DESIGN

Smith AF1, Boureu C2, Lafuma A3, Mlmaud V4, Somlay K1

1Alcon Laboratories Ltd, Hemel Hempstead, Herts, UK, 2Ophthalmologist, Paris, France, 3Cemka-Eval, Bourd-la-Reine, France, 4University of North Carolina, Chapel Hill, NC, USA

OBJECTIVE: To compare the rate of capsulotomy with Nd:Yag laser following cataract surgery involving intra-ocular (IOL) implantation with three square edge IOLs (hydrophobic acrylic single piece IOL: Acrysof SA60AT, Alcon, hydrophobic acrylic multi-piece IOL: AR40E, AMO, and hydrophilic acrylic single piece IOL: XL-Stabi, IOLTech) after three years follow-up. METHODS: A retrospective review of patients with at least one eye having been implanted with an IOL, aged 50 to 85 years at the time of surgery, operated on for cataract in 2001 or 2002 in 10 French surgical centers. Centers were recruited if they had implanted at least 2 of the studied types of IOLs in order to study center effect. Medical charts of patients meeting inclusion and exclusion criteria were reviewed to collect information during the three year period following cataract surgery to identify patients who had posterior capsular opacification (PCO) requiring Nd:YAG laser post-operatively. Data on the type of IOL implanted was extracted from the patients’ charts, as was the date and outcome of the Nd:YAG laser intervention. Kaplan-Meier survival curve analysis with time to Nd:YAG laser analysis was performed on the data and adjusted in Cox models for center effect due to possible differences in Nd:YAG practices. RESULTS: A total of 777 cataract patients were included and analyzed (n = 236 for SA60AT, n = 236 for AR40E, n = 265 for XL-Stabi). The 3-year rates of cataract patients with the operated eye free of PCO requiring Nd:YAG laser treatment were 88.3% with SA60AT, 75% with AR40E and 49.1% with XL-Stabi (p < 0.0001). Adjusted Cox model gave a risk-ratio (RR) of 2.88 for AR40E (p < 0.0001) and a RR of 5.217 for XL-Stabi (p < 0.0001) compared to SA60AT (reference). CONCLUSION: Cataract patients receiving the Acrysof SA60AT IOL implant had the lowest rate of PCO requiring Nd:YAG laser treatment post-operatively.

PEY7

MODELLING THE HEALTH ECONOMIC IMPACT OF OLOPATADINE COMPARED TO BRANDED AND GENERIC SODIUM CROMOGLYCATE IN THE TREATMENT OF SEASONAL ALLERGIC CONJUNCTIVITIS IN THE UK

Smith AF1, Clegg J2, Guest J3

1Alcon Laboratories Ltd, Hemel Hempstead, Herts, UK, 2Catalyst Health Economics Consultants, Northwood, Middlesex, UK

OBJECTIVE: This study estimated the incremental costs of using olopatadine (Opatanol) compared to branded cromoglycate (Opticrom) and generic cromoglycate in the treatment of season allergic conjunctivitis (SAC) in the UK. METHODS: A literature-based decision model was constructed depicting the management of SAC sufferers >4 years of age over four months (a typical allergy season). The model considers the decision by a GP to initially treat a patient with olopatadine (1 drop in affected eyes twice daily), branded and generic cromoglycate (1 or 2 drops in affected eyes 4 times daily). Whilst published studies demonstrate olopatadine’s greater symptom reduction compared to cromoglycate, there was no evidence of any significant differences between the two treatments in terms of days of treatment and overall probability of being successfully treated. Therefore, for the purposes of this analysis both drugs were assumed to be equally effective. Consequently, a cost-minimisation analysis was performed to identify the least costly alternative from the perspective of the UK’s National Health Service (NHS). RESULTS: Starting treatment with olopatadine is expected to lead to a health care cost of GBP 92 (95% CI:46–150) over four months compared to GBP 109 (95% CI: 165–166) with branded cromoglycate and GBP 95 (95% CI: 51–132) with generic cromoglycate. Consequently, use of olopatadine instead of branded or generic cromoglycate is expected to lead to a 16% and 3% reduction in health care costs respectively over four months of treatment. This cost-difference is primarily due to fewer GP visits among olopatadine-treated patients. CONCLUSIONS: Use of olopatadine instead of branded or generic cromoglycate affords an economic benefit to the NHS. Hence, within the limitations of our model, olopatadine is the preferred first-line treatment for use in SAC sufferers, since it is expected to release health care resources for alternative use and may offer better symptom reduction to patients.