matched samples of employees with osteoarthritis (OA) and non-FM controls. **METHODS:** Samples were selected from a U.S. claims database of privately insured beneficiaries. Employees in the FM sample had ≥2 fibromyalgia diagnoses in 1999–2005 (with ≥1 in 2002–2005) and were continuously enrolled in 2005. Controls and employees with OA had no FM claims and were matched to the study sample on age, gender, and region. Costs are reported for 2005 experience. Nonparametric Wilcoxon tests were used to determine statistically significant differences in skewed variables including costs. Chi-square tests were used to test for differences in for categorical variables. **RESULTS:** Mean age in the FM sample was 50.1 years and 51.6% were female. Compared to control and OA samples, employees with FM had higher rates of depression, anxiety, chronic fatigue syndrome, and many pain diagnoses. The FM sample used more medical care overall, especially emergency department visits, specialty physician visits, and prescriptions. Direct (medical and prescription drug) costs in the FM sample were significantly higher than control sample costs ($7286 vs. $3915, $p < 0.0001$), and approached OA sample costs ($7286 vs. $8325, $p = 0.3758$). Prescription costs comprised a relatively large proportion of total FM costs; prescription cost levels were comparable to employees with OA ($1630 vs. $1341, $p < 0.3541$) and significantly higher than controls ($1630 vs. $755, $p < 0.0001$). Work loss costs in the FM sample ($2913) were significantly higher than those of control ($1359, $p < 0.0001$) and OA ($2537, $p < 0.0001$) samples. **CONCLUSIONS:** Fibromyalgia imposes significant economic burden. Average total costs among employees with fibromyalgia were almost twice those of matched controls and approximated costs of employees with osteoarthritis. Indirect costs were more than double those of controls and even exceeded costs of osteoarthritis patients with similar demographic profiles.

NE2

IMPACT OF PATIENT COMORBIDITIES ON PHARMACOLOGICAL TREATMENT OF INSOMNIA: AN ANALYSIS OF THE NATIONAL AMBULATORY MEDICAL CARE SURVEY DATA: 1995–2004

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OBJECTIVES: Patients with insomnia are likely to have comorbidities that could affect treatment options. Hence the objective of this study was to examine the prevalence of comorbidities and their impact on the pharmacological treatment of insomnia in US primary care settings. **METHODS:** A retrospective data analysis of the National Ambulatory Medical Care Survey from 1995 to 2004 was performed. Patients aged ≥18 years, who had a physician visit with a diagnosis of insomnia in US outpatient settings were included in this study. Office visits of patients with primary or secondary insomnia/sleep complaints and resultant diagnoses were included in the analysis. Data were stratified according to patient characteristics, physician specialty, resulting diagnosis and medications prescribed. Multivariate logistic regression models were used to examine impact on prescribing pharmacotherapy for insomnia. **RESULTS:** A total of 5487 unweighted patient visits for insomnia were identified from the year 1995–2004, representing 107.4 million patients in the overall U.S. population. Official visits for insomnia were more common in females (60.4%), with an increasing prevalence in older patients. Approximately 41% of the patients with insomnia had a concomitant diagnosis of a mental comorbidity with higher prevalence of anxiety (15.6%) followed by episodic mood disorders (14.9%) and depression (7%). Patients with mental comorbidities were 35% less likely to receive pharmacological treatment for insomnia than those without mental comorbidities (OR: 0.65, 95% CI: 0.51–0.84). Subgroup analysis of type of mental comorbidity revealed that patients with comorbid anxiety were 42% less likely to receive pharmacological treatment for insomnia than those without anxiety (OR: 0.58, 95% CI: 0.45–0.73). **CONCLUSION:** Mental comorbidities such as episodic mood disorder, anxiety, and depression are prevalent in patients with insomnia and affect receipt of pharmacological therapy for insomnia. Health care professionals should consider the impact of mental comorbidities while treating patients with sleep difficulties.

NE3

THE IMPORTANCE OF MODIFYING THE COURSE OF ALZHEIMER'S DISEASE: OLDER AMERICANS' RISK-BENEFIT PREFERENCES FOR NEW TREATMENTS

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OBJECTIVES: The objective of this study is to quantify the strength of preferences of older Americans for possible Alzheimer's disease (AD) treatment benefits by estimating their willingness to accept the risk of death or severe disability in exchange for modifying the course of AD. Currently, AD has no cure. A breakthrough in treatment that modifies the underlying AD disease process would be a major achievement with enormous medical and social benefits. Little is known concerning older Americans' perceptions about AD and their willingness to accept risk to avoid AD. **METHODS:** American residents aged 60 years and older who have not been diagnosed with AD, and are not taking prescription medicines to treat AD, memory problems or dementia completed an online survey questionnaire that included a series of stated-choice trade-off tasks. Respondents chose between pairs of hypothetical treatment alternatives, each including different 7-year AD disease-progression profiles and risks of serious adverse events that would result in death or severe disability. We used mixed-logit methods to estimate the maximum acceptable risk (MAR) of serious adverse events that would result in death or severe disability. **RESULTS:** 2146 respondents completed the survey. Mean (SD) age was 70 (7.4). In return for preventing AD from progressing beyond the mild stage, the mean MAR (95% CI) was 46.8% (40.3%–54.3%); that is older Americans were willing, on average, to accept an increase in the risk of death or severe disability from stroke of nearly 50% to avoid progression to the moderate and severe stages of AD. **CONCLUSION:** Older Americans' willingness to accept significant increases in the risk of death or disability in exchange for treatments that modify the course of AD indicates the value of such treatment benefits.

NE4

COST-UTILITY ANALYSIS EVALUATING LIDOCAINE 5% MEDICATED PLASTER RELATIVE TO GABAPENTIN FOR POST-HERPETIC NEURALGIA IN SCOTLAND

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OBJECTIVES: To assess the cost-effectiveness of using a lidocaine 5% medicated plaster (lidocaine plaster) in the treatment of post-herpetic neuralgia (PHN) in place of gabapentin from the perspective of the Scottish National Health Service. **METHODS:** A Markov model was constructed in TreeAge to calculate the costs and benefits of gabapentin and lidocaine plaster when used in primary care over a six-month time horizon in patients with