Illness and used to estimate the budgetary impact of therapies that reduce bone loss. Whereas the number of osteoporotic fractures and women suffering from PMO (T-2010 and 2020, the number of women aged 50 years is expected to increase by 9%, whereas the number of osteoporotic fractures and women suffering from PMO (T-score < -2.5 or history of fracture) is expected to increase by 11% and 12% respectively. CONCLUSIONS: A PMO disease model was developed and validated against Swedish data. This model can be adapted to other countries to assess the burden of illness and used to estimate the budgetary impact of therapies that reduce bone loss.

METHODS: For validation purposes, the model was developed for Sweden (where the epidemiology of osteoporosis is well documented) and provided estimates for each year of the study period, the “incident cohort” is defined as women experiencing a first osteoporotic fracture, identified and run through a Markov model of 1-year cycles until 2020. Health states were based on the number of fractures (1, 2, 3, 4+ and death). Fracture by site was tracked for each health state (hip, vertebral, non-hip non vertebral). Transition probabilities reflected site-specific risk of death and subsequent fractures. BMD was included as a model output and reflected difference between women with and without a history of fracture. Model inputs included census from 1970 to 2020, incidence of fracture, relative risk of subsequent fractures based on prior fracture, relative risk of death following a fracture by site, mean and standard deviation BMD by age. RESULTS: Model predictions averaged across age groups estimated the incidence of hip, vertebral and other osteoporotic fractures within a 5% margin of error compared to published data. Between 2010 and 2020, the number of women aged 50+ years is expected to increase by 9%, whereas the number of osteoporotic fractures and women suffering from PMO (T-score < -2.5 or history of fracture) is expected to increase by 11% and 12% respectively. CONCLUSIONS: A PMO disease model was developed and validated against Swedish data. This model can be adapted to other countries to assess the burden of illness and used to estimate the budgetary impact of therapies that reduce bone loss.

CONCLUSIONS: The incidence of macular degeneration (AMD) was 7.6 years, 11.0 years and 14.9 years in the study group, respectively. The mean age was 75 years and the sex ratio was close to 1 male/1 female. No demographic or co-morbidity differences between treatment sequences were observed. At 30 months, 66.5% of the XX patients had not failed (remain with the same treatment sequence), versus 60.5% of the LG and 75.1% of the TD patients (Wilcoxon, P = 0.005). At 60 months these results became, 42.2%, 49.9% and 52.0%, respectively (Wilcoxon, P = 0.004). Treatment failure was defined as a prescription change (adding or removing a topical treatment). Time to treatment failure was compared using Wilcoxon test applied to survival curves. Adjustment on confounding variables was performed with the propensity score method using a logistic stepwise regression. RESULTS: 1562 patients were treated by XX, 110 by LG and 114 by TD. Mean age was 75 years and the sex ratio was close to 1 male/1 female. No demographic or co-morbidity differences between treatment sequences were observed. At 30 months, 66.5% of the XX patients had not failed (remain with the same treatment sequence), versus 60.5% of the LG and 75.1% of the TD patients (Wilcoxon, P = 0.005). At 60 months these results became, 42.2%, 49.9% and 52.0%, respectively (Wilcoxon, P = 0.04). Adjustment on confounding variables did not change these estimates. CONCLUSIONS: According to the UK-GPRD information, the Travatan-DuoTrav treatment sequence was associated with longer treatment persistence.

CONCLUSIONS: This study confirms the efficacy of Verteporfin in real life setting but treatment rate was lower than in pivotal studies.