OBJECTIVE: Hospitalization and inpatient charge comparisons for bipolar and manic patients receiving atypical and conventional antipsychotics. METHODS: Analysis of a claims database (1999–2003) representing 50 million US insured patients identified 12,835 treatment episodes of monotherapy for bipolar and manic disorders with atypicals (risperidone, olanzapine, quetiapine, ziprasidone) and conventionalals (haloperidol, perphenazine, thioridazine, thiothixene). Hazard ratios (HR) for hospitalization risks were estimated with Cox regression adjusting for patient characteristics. Inpatient charges were based on these estimates and estimated hospital stays. RESULTS: Risperidone and olanzapine had significantly (P < 0.05) higher risks of hospitalization than quetiapine (HR 1.185 and 1.187, respectively) and trended (P < 0.10) toward higher risks than ziprasidone (HR 1.443 and 1.447, respectively), translating into higher inpatient charges of $194–$389 per patient per year. On comparing the atypicals in manic rapid cyclers (a high hospitalization subgroup), risperidone had a significantly (P < 0.05) higher risk of hospitalization than olanzapine (HR = 3.309) and olanzapine trended (P < 0.10) toward longer stays than quetiapine (7.56 days longer), both translating into higher inpatient charges.

CONCLUSION: In treating bipolar and manic disorders, risperidone and olanzapine may have higher risks of hospitalization than quetiapine. In treating manic rapid cyclers, olanzapine may have a lower risk of hospitalization than risperidone, but longer stays than quetiapine.

PREVALENCE AND COST OF BIPOLAR DISORDER AND TREATMENT WITHIN A MANAGED CARE ORGANIZATION

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OBJECTIVES: To determine the prevalence of patients with bipolar disorder (BD) and compare their annual health care costs to patients with other mental health disorders, in a large United States managed care organization. METHODS: This was a retrospective claims analysis of approximately 1.4 million commercial health plan members with mental health benefits. Adults with a primary or secondary diagnosis of a mental health disorder in 2002 were identified and the prevalence of BD calculated. Those continuously enrolled throughout 2003 (follow-up period) were stratified to one of two cohorts: “BD” (Bipolar Disorder) or “OMHD” (Other Mental Health Disorder). Patient demographics, pharmacological treatments, and health care charges were compared between cohorts, adjusting for potential confounding factors of age, gender, and comorbidity. RESULTS: During 2002, there were 6581 patients (mean age 40.3 years; 65.7% female) with BD, yielding an overall prevalence rate of 4.68 per 1000 members. Among the 64,434 continuously enrolled mental disorder patients in 2003, 3,043 (4.7%) were classified as “BD” and 61,391 (95.3%) were classified as “OMHD”. Patients in the “BD” group were younger (41.7 vs. 43.0 years; p < 0.0001) with higher Charlson comorbidity index (0.56 vs. 0.47; p < 0.0001) compared to the “OMHD” group. Less than half (38.3%) of “BD” patients received a mood stabilizer (lithium, valproate, or carbamazepine) and 20.0% received no psychotropic medication. Adjusted pharmacy, medical, and total health care charges were higher in the “BD” group compared to “OMHD”: $2641 vs. $1071, $13,419 vs. $8422, and $16,059 vs. $9493 respectively (p < 0.0001 for all three comparisons). CONCLUSIONS: Compared to the national prevalence rate of 1%, BD may be under-diagnosed, and pharmacologic therapy underutilized within managed care. Patients with BD incurred greater health care charges compared to other mental health disorders. Efforts aimed at improving diagnosis and treatment of BD may optimize care and cost of managing this patient population.

A CASE-CONTROL STUDY ON SECOND-GENERATION ANTIDEPRESSANT USE IN PATIENTS WITH BIPOLAR DISORDER

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OBJECTIVES: To assess the clinical outcomes of modern second-generation antidepressant medication use in bipolar disorder, with a focus on the risk of induced manic-switching for adult patients with bipolar depression. METHODS: Bipolar disorder subjects were identified with a new depressive episode in a national managed-care plan between January, 1998 and December, 2002. A case-control study design was applied for which cases and controls were defined by whether having mania-related visits in the 12-months continuous enrollment after...