tive visits between 9-15, 15-21, and 21-27 months after surgery were identified for 12-month, 18-month, and 24-month endpoints. All available data relating to the procedure, demographics, comorbidities, and prior surgical history were considered as potential predictors of %BMI loss. Regression models, using multiple model selection procedures, were fitted at each endpoint. RESULTS: The population consisted of 31,443 LAGB, 40,352 RYGB, and 2194 VSG patients, of whom 79% were females, and the mean age was 47.7 years. Eighty-three articles were included. Strength and function improve from baseline to 20 patients.

OBJECTIVES: The objective of this analysis is to assess impact on hospital costs for patients undergoing sugammadex for the reversal of deep neuromuscular blockade compared to no reversal agent. METHODS: An economic model reflecting resource use and costs associated with neuromuscular block and its reversal, and residual blockade, was constructed for the Swedish healthcare setting. Sugammadex was compared to no reversal agent. Clinical trial data were used to estimate time savings relating to shortened reversal in the operating room (OR). Costs of OR time were derived from labor costs for different types of OR staff. Resource use associated with clinical sequelae of residual block (aspirating neurotoxicity, muscle weakness, and obstruction) was estimated from the literature, where available. Unit costs were taken from published price lists of the state-owned pharmacy chain and, published hospital price lists. RESULTS: If all OR staff modeled (anesthetist, two surgeons and two nurses) can be re-allocated to realize time savings, use of Sugammadex compared to no reversal of deep neuromuscular blockade is estimated to save ~553 SEK per reversed patient. This corresponds to an increase in drug costs of 1953 SEK, which is more than fully offset by a decrease in the costs of OR staff time and clinical sequelae of residual block (~2006 SEK). In a worst case scenario, if only the anesthetist, one surgeon and one nurse realize time savings, costs would be increased (594 SEK) compared to no reversal. Results were sensitive to OR staff costs and time savings. CONCLUSIONS: Sugammadex for reversal of deep neuromuscular blockade can potentially lead to cost savings in the Swedish healthcare system. The design of the BOLD registry are sufficiently robust to enable the evaluation of predictors of bariatric surgery success including surgery type, comorbidities, baseline BMI and key demographic variables.

PSU4 OPEN VERSUS ENDOVASCULAR REPAIR FOR ABDOMINAL AORTIC ANEURYSM: AN EXPLORATION WITH DISCHARGE AND POST-DISCHARGE MORTALITY DATA

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OBJECTIVES: To explore the feasibility of using linked hospital discharge and vital statistics death records to study the comparative effectiveness of repairs for unruptured abdominal aortic aneurysm (AAA) using traditional open aortic repair (OAR) and endovascular aortic repair (EVAR). METHODS: Linked hospital discharge and vital statistics death records of the California Office of Statewide Health Planning and Development were merged for 2000-2007. Hospitalized patients for AAA with OAR and those with EVAR were identified. Demographic characteristics, comorbidities, rates of complication, mortality, readmissions were compared between these two groups. Descriptive statistics, Kaplan-Meier survival analysis, and propensity scores were used. RESULTS: We identified 8343 AAA patients with OAR and 6602 AAA patients with EVAR between 2000Q3 and 2007. The yearly number of OARs declined from 1,766 to 80, while EVARs increased from 676 to 1,389. Patients receiving OAR were more acutely ill and likely to be admitted through ED than those with EVAR (8.5% vs. 2.8%). Preliminary results indicated that the inpatient mortality rate was higher for OAR than EVAR (4.68 vs. 0.96 per 100; P = 0.001). Preliminary results indicated that the inpatient mortality rate was higher for OAR than EVAR (4.68 vs. 0.96 per 100; P = 0.001). Precise variables were used for 2000-2007. Inpatient aquatic PT (Australia) do not reduce hospital length of stay versus usual care. The bariatric surgery may alter the upward trajectory of health utilization was negative, indicating a decrease post-surgery. The estimate of physician and outpatient costs, the mean estimate per obese resident was $696, following by $545 for overweight, $523 for underweight, and $480 for normal weight residents. Compared to norm weight, obesity, overweight and underweight were associated with increases of $217, $65 and $44, respectively. There were 217 bariatric surgery recipients in 2006. Health care costs and utilization two years post-surgery were greater than two years post-surgery. The marginal change in health care costs and utilization between 2004 and 2005, however, was positive, indicating an increase prior to surgery. In contrast, the marginal change in health care costs and utilization was negative, indicating a decrease post-surgery. The estimate of total physician and hospital costs associated with bariatric surgery was $12,175.79 (SE: $586.75).

PSU5 PREVALENCE OF CARDIOVASCULAR RISK FACTORS AMONG PATIENTS UNDERGOING ELECTIVE CORONARY ARTERY BYPASS SURGERY

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OBJECTIVES: This study was to estimate economic burden of obesity and to assess the impact of bariatric surgery on health care costs and utilization in adults in Alberta. METHODS: Multivariate regression models were developed to estimate the impact of BMI on physician, outpatient and inpatient costs and visits. A pre-post analysis over a 5-year period was conducted to compare the cost and visits before and after surgery. Patients who received bariatric surgery in 2006 were identified using the the Canadian Classification of Health Interventions (CCII) codes that correspond to bariatric surgery. Total physician, inpatient and outpatient costs and visits were calculated across all patients, over a period of two years before and two years after surgery. Health utilization data from Alberta provincial health administrative databases were linked with epidemiologic and demographic data contained in Canadian Community Health Survey (CCHS). RESULTS: When combining physician and outpatient costs, the mean estimate per obese resident was $696, following by $545 for overweight, $523 for underweight, and $480 for normal weight residents. Compared to normal weight, obesity, overweight and underweight were associated with increases of $217, $65 and $44, respectively. There were 217 bariatric surgery recipients in 2006. Health care costs and utilization two years post-surgery were greater than two years post-surgery. The marginal change in health care costs and utilization between 2004 and 2005, however, was positive, indicating an increase prior to surgery. In contrast, the marginal change in health care costs and utilization was negative, indicating a decrease post-surgery. The estimate of total physician and hospital costs associated with bariatric surgery was $12,175.79 (SE: $586.75). CONCLUSIONS: Obesity placed a large economic burden on health care system. The bariatric surgery may alter the upward trajectory of health utilization was negative, indicating a decrease post-surgery. The estimate of total physician and hospital costs associated with bariatric surgery was $12,175.79 (SE: $586.75). CONCLUSIONS: Obesity placed a large economic burden on health care system. The bariatric surgery may alter the upward trajectory of health utilization was negative, indicating a decrease post-surgery. The estimate of total physician and hospital costs associated with bariatric surgery was $12,175.79 (SE: $586.75).