A total of 183 patients were enrolled, of these, Rabinovitz et al identified through a query of outpatient claims with an ICD-9 code for RA and practice code for Jefferson Rheumatology Associates, Philadelphia, PA. Patients who met inclusion criteria of 218 years old and having received etanercept or adalimumab in the past 3 past years were administered a one-time observational survey developed by the investigators. RESULTS: The study included thirty patients, five of which had used both adalimumab and etanercept. The overall prevalence of ISRs was 56.3% (9 patients out of 16) for adalimumab and 84.2% (12 patients) for etanercept. Clinical characteristics of ISRs included erythema (44.4%–68.8%), pruritus (44.4%–68.8%), and swelling (33.3%–56.3%). Only one patient (3.3%) in the cohort was pre-medicated for ISR. Three patients in the adalimumab (n = 9, 33.3%) and one patient in the etanercept group (n = 16, 6.25%) called their physician when experiencing an a.time ISR. Lee et al. used the Markov model to estimate the impact of treatment on the cost savings in the 1 year of treatment (Delmas, 2008). The primary outcome of this analysis was to determine the cost-effectiveness of risendronate compared to alendronate at generic pricing using each of the cost-effectiveness data in a high risk FMO population in the U.S. METHODS: A validated Markov model of osteoporosis (Tosteson, 2001) was used to estimate the impact of therapy and the cost, quality-adjusted life years (QALYs). The model simulated all of the women 65+ with BMI >25 and a previous vertebral fracture, treated with risendronate or alendronate for one year. Associated costs and QALYs were tracked for an additional two years in each arm. Hip fracture incidence and mortality rates, as well as drug (generic alendronate 93.5% lower than risendronate) and hip fracture costs were extracted from published literature. RESULTS: In a cohort of 5,000 women treated with risendronate versus alendronate, the model predicted 25 fewer hip fractures and 8.41 additional QALYs, resulting in a cost savings of $330,378. Extrapolating to a population of 50,000 women with a prior vertebral fracture in the U.S., suggests that risendronate prevents over 114,000 fractures in rough 4.6 million women at cost savings of over $1,515 million. A sensitivity analysis assuming treatment for 2 years and parity efficacy in year 2 resulted in a cost per QALY gained for earlier fracture protection of $9925 (cost per fracture averted: $3419) when treating with risendronate versus alendronate in the population 65+. Risendronate remains cost-saving in the 80+ population, CONCLUSIONS: Risendronate produces a “real world” data this analysis suggests risendronate’s early fracture protection results in favorable cost-effectiveness versus generic alendronate, despite its higher drug cost.

The costs of non-vertebral osteoporotic fractures in the United States

Bethua et al. assessed absolute (CIF) and incremental (ICF-9, GM code ICD-9, 733.0) costs of osteoporotic fracture patients with non-vertebral (NV) fractures. METHODS: Osteoporosis patients (n = 99,986) were identified (1998–2006) from an employer claims database. (18,000,000 privately-insured beneficiaries; ages 18–64) and the Medicare Standard Analytic Files 5% sample (ages 65+). Osteoporotic patients with NV fracture (femur, pelvis, lower leg, upper arm, forearm, rib, or hip) were randomly matched on age, gender, employment status, and geography to osteoporotic controls.