insurance, physician type, region, pre-dialysis co-morbidities, and pre-dialysis costs were used to evaluate the impact of pre-dialysis paricalcitol treatment on hospitalizations, outpatient services, and medication use in first year of dialysis. RESULTS: Multivariable analysis demonstrated predialysis paricalcitol use was associated with statistically the largest reductions in all-cause hospitalizations (68% reduction in >65 years old receiving dialysis). CONCLUSIONS: Paricalcitol treatment for SHPT prior to dialysis is associated with fewer CKD-related medications; and all-cause and CKD-related outpatient services and hospitalizations in the first year of dialysis compared to no VDR activator treatment. Payers should consider these findings when making coverage decisions regarding the use of paricalcitol. Further studies are needed to confirm these results.

**CONCLUSIONS:** From an institutional perspective, solifenacin was found that with US$411 available, a solifenacin treatment would be more cost-effective for the institution. Nonetheless, when conducting the probabilistic analysis, it is a dominated alternative and that oxybutynin and solifenacin are positioned within the efficiency line. The cost-effectiveness (CE) for each strategy from a societal perspective, based on literature-derived estimates for the probabilities and costs of different outcomes. Multiple one-way and probabilistic sensitivity analysis were conducted to examine the robustness of the results. In the base-case analysis, before surgery, an improved survival by 0.018 QALYs compared with immediate surgery, at an incremental cost of $55,244/QALY, while the ICER of WW relative to surgery was $11,712/QALY. In the base-case, percutaneous biopsy is more expensive and less effective than WW. The treatment decision was most sensitive to variation of the degree of tumor growth that triggers surgery, utility of living with a mass during WW, and the probability of diagnostic biopsy for benign tumors. Choice of WW versus surgery critically depends on patients’ preferences for tumor removal and the risk of recurrence post surgery. In probabilistic sensitivity analysis, surgery was the most favored strategy when the willingness to pay (WTP) is less than $10,000/QALY. WW was favored over surgery when WTP is > $60,000. CONCLUSIONS: Although WW results in the highest life-time utility, the certainty of WW depends on patients’ preferences for living with a possibly malignant mass and histories of watched masses during surveillance, which are poorly understood. Biopsy would be favored if its costs decrease and diagnostic certainty increases in the future.

**ECONOMIC EVALUATION ON THE USE OF OXYBUTYNIN, TOLTERODINE, AND SOLifenacin IN PATIENTS WITH HYPERACTIVE BLADDER**

De Lago Acosta A1, Salinas G2, Idrovo J3, Zapata L4, Alanis A1, Rico P

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OBJECTIVES: The Combination of Avodart® and Tamsulosin (CombAT) study shows that combination therapy provides a significantly greater degree of benefit than tamsulosin or dutasteride monotherapy in the treatment of moderate to severe benign prostatic hyperplasia (BPH). The objective of this study was to assess the cost-effectiveness of combination therapy with tamsulosin and dutasteride relative to either of monotherapies using recent information from the CombAT study. METHODS: A decision analytic model was constructed using a Markov model and a 1-year cycle time. It estimated clinical and cost consequences of dutasteride and tamsulosin, dutasteride, and combination therapy. Analyses were conducted for a 20-year time frame from the societal perspective. All costs are presented in 2009 US dollars, and costs and outcomes were discounted at a rate of 3% per year. Outcomes were expressed in terms of the incremental cost-effectiveness ratio (ICER), defined as the ratio of additional costs to additional QALYs. Sensitivity analyses were conducted on model probabilities, cost estimates, utility values and the discount rate. RESULTS: At both moderate and severe symptom levels, tamsulosin was dominated by dutasteride, that is, more costly and less effective than dutasteride. Compared to dutasteride, combination therapy was more expensive but more effective with the ICERS of $197,625 for moderate symptoms and $241,032 for severe symptoms. However, considering a societal cost-effectiveness threshold of $150,000 per QALY, combination therapy was not cost-effective compared to dutasteride. In most sensitivity analyses, these results were not sensitive to changes in model parameters. CONCLUSIONS: This study showed that tamsulosin was more costly and less effective than dutasteride, and the ICERS for combination therapy compared to dutasteride were higher than the cost-effectiveness threshold. Therefore, combination therapy is not cost-effective relative to dutasteride for moderate-to-severe BPH patients.

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