BURDEN OF PREMENSTRUAL DYSPHORIC DISORDER ON HEALTH-RELATED QUALITY OF LIFE
Yang M1, Wallenstein GV1, Hagan MA2, Chang J3
1QualityMetric Inc, Lincoln, RI, USA, 2Berlex Laboratories, Inc, Wayne, NJ, USA

OBJECTIVES: Although several studies have described the burden of Premenstrual Dysphoric Disorder (PMDD) impacts women’s lives, few undertook a quantitative approach. This study is an attempt to quantify the burden of PMDD on health-related quality of life (HRQoL) in comparison to specific chronic conditions in the US general population. METHODS: The burden of PMDD on HRQoL was estimated by comparing SF-12 scores between women identified as being “at risk for PMDD” with SF-12 scores observed in the general US population. Additional comparisons were made to several chronic health conditions. SF-12 normative values of the general population were estimated through regression adjusted to match the age and disease comorbidity of the PMDD patient group. Significance tests between the means across samples were compared. Medical expenditures were estimated and compared for women who were “at risk for PMDD” and women with no reported chronic conditions. RESULTS: All SF-12 measures of PMDD were significantly below the adjusted US general population norms. The burden of PMDD was greater on mental/emotional than on physical HRQoL. The burden of PMDD on HRQoL was greater than that of chronic back pain; similar to type 2 diabetes, hypertension, osteoarthritis and rheumatoid arthritis; and largely comparable to depression. Age, PCS, and MCS scores were used to predict monthly medical expenditures using data from the annual Medical Expenditures Panel Survey (2001). The mean predicted monthly medical expenditure for women “at risk for PMDD” was $222.3 (SD = $107.3) and $134.0 (SD = $43.4) for women with no reported chronic conditions (p < 0.0001). CONCLUSION: PMDD is associated with substantial burden on physical and mental aspects of HRQoL, and may be related to increased medical expenditures.
health conditions, and the demographic variables. We also report QOL weights for the self-reported health state and priority health conditions, by the demographic variables. Finally, ordinary least squares and CLAD regression equations were used to estimate adjusted QOL weights for these variables. CONCLUSION: By providing nationally representative QOL weights for self-reported health status and priority health conditions, by demographic variable, we have facilitated the use of large national surveys for conducting cost-utility analysis and increased their value to researchers and policy makers.

**PIH12**

IDENTIFYING MEANINGFUL IMPROVEMENTS IN VASOMOTOR SYMPTOMS AMONG MENOPAUSAL WOMEN USING DESVENLAFAXINE SUCCINATE

Wyrrich KW1, Yu H2, Bobula JD3

1Saint Louis University, St. Louis, MO, USA, 2Wyeth Research, Collegeville, PA, USA

OBJECTIVES: To identify treatment satisfaction thresholds for interpreting treatment-related changes in vasomotor symptoms, and determine the doses of desvenlafaxine succinate (DVS) that effectively provide relief of vasomotor symptoms considered important by menopausal women. METHODS: Efficacy and treatment satisfaction were assessed in 620 postmenopausal women with ≥7 moderate-to-severe vasomotor symptoms/day participating in a double-blind, placebo-controlled trial randomized to placebo or DVS 50, 100, 150, or 200 mg. Number and severity of hot flushes and number of nighttime awakenings were recorded in daily diaries for 12 weeks of treatment. Responses to the Menopausal Symptoms Treatment Satisfaction Questionnaire at week 12 were compared with efficacy results. The treatment satisfaction threshold was anchored by the difference in the average symptom change among women reporting “neutral” satisfaction compared with women reporting “satisfied,” without deference to treatment group. RESULTS: Greater percentages of participants in the DVS groups reported being “satisfied” or “extremely satisfied” with daytime and nighttime control of hot flushes compared with placebo being “satisfied” or “neutral” satisfaction compared with women reporting difference in the average symptom change among women reporting “neutral” satisfaction compared with women reporting “satisfied,” without deference to treatment group. CONCLUSION: The decision tree was designed by IMSS experts according to clinical guidelines. Univariate and bivariate sensitivity analyses were carried out. RESULTS: Treatment for RSA with AAC showed a mean cost per cured patient of $79.8 USD. The remaining antibiotics had a higher cost per unit of success, and therefore the results showed that AAC was the best alternative considering this criterion. The therapy that showed a lower percentage of cured patients in RSC was clindamycin (cost per unit of success 666.3 USD); however, the therapeutic alternative with the lowest cost per successful unit was the one based on ciprofloxacin, which dominates gatifloxacin and AAC. CONCLUSION: Ciprofloxacin is a cost-effective alternative for both, RSA and RSC; however, AAC is also a good alternative in RSA when resources are constrained. Sensitivity analysis showed the strength of the base study results.

**PIN2**

RETROSPECTIVE COMPARISON OF TREATMENT OUTCOMES AMONG HEPATITIS C PATIENTS TREATED WITH PEGYLATED INTERFERON 2A OR 2B PLUS RIBAVIRIN AT DIFFERENT VA MEDICAL CENTERS

Dinges E1, Ho SB4, Morreale AP1, Plowman BK1, Dollarhide A1, Meyer JM1, Moise-Broder P5, Davis S1

1VA San Diego Health care System, San Diego, CA, USA, 2Southern Arizona VA Health care System, Tucson, AZ, USA

OBJECTIVES: Assess differences in treatment response between weight-based peginterferon alfa-2b (PEG2b) or standard dosed peginterferon alfa-2a (PEG2a) plus weight-based ribavirin (RBV); identify patient variables that may predict treatment response; and evaluate differences in cost-effectiveness. METHODS: We compared two retrospective assessments of the treatment of hepatitis C virus (HCV) infected patients at two different VAs. The primary outcome was sustained virologic response (SVR), defined as an undetectable viral load 6 months post-therapy completion. All patients were treatment naive and had received at least 2 doses of PEG 2a or 2b plus RBV prior to January 2005 (n = 151). RESULTS: SVR among genotype 1 and genotype 2/3 patients was 21% and 71% for PEG2a versus 20% and 70% for PEG2b, respectively. Premature treatment discontinuation due to an adverse event occurred among 36% of PEG2a and 40% of PEG2b patients. The overall relapse rate was 29% for each regimen. There was a statistically significant difference in baseline age and weight between the two groups. Overall mean age ±SD was 52 ± 6 years for PEG2a and 49 ± 7 years for PEG2b (P = 0.001); overall mean body weight was 94 + 18 kg for PEG2a and 86 + 13 for PEG2b (P = 0.008). Cost per successful outcome (defined as SVR) for genotype 1 and genotype 2/3 patients was $36,567 and $4958 for PEG2a versus $38,670 and $5060 for PEG2b, respectively. CONCLUSION: There were no statistically significant differences between peginterferon alfa-2a and peginterferon alfa-2b in terms of treatment response or cost-effectiveness; however dissimilarities in the variables associated

**INFECTION—Clinical Outcomes Studies**

**PIN1**

COST-EFFECTIVENESS OF ACUTE AND CHRONIC RHINOSINUSITIS AT THE MEXICAN INSTITUTE OF SOCIAL SECURITY (IMSS)

Muñoz-Cardin MDL1, Nevarez-Sida A2, García-Contereras P2, Mendieta-Sevilla SR1, Constantino-Casas P2

1Mexican Institute of Social Security, Mexico City, Mexico, 2Mexican Institute of Social Security, Mexico City, Distrito Federal, Mexico

OBJECTIVES: To determine the cost-effectiveness of treatments for patients with acute (RSA) and chronic rhinosinusitis (RSC) that are available at the Mexican Institute of Social Security (IMSS). METHODS: Cost-effectiveness analysis of RSA and RSC treatment from an institutional perspective. Effectiveness outcome was defined as the percentage of cure and this information was taken from the literature. Use of resources was obtained from an expert panel and unit costs were taken from Administrative and Financial departments from IMSS. Estimated costs are expressed in US dollars (USD). A decision tree with a Bayesian approach included the following therapeutic alternatives: ciprofloxacin, gatifloxacin, trimetoprim/sulfamethoxazol (TMP/SMX), amoxicilin/clavulanic acid (AAC) and clindamycin. The decision tree was designed by IMSS experts according to clinical guidelines. Univariate and bivariate sensitivity analyses were carried out. RESULTS: Treatment for RSA with AAC showed a mean cost per cured patient of $79.8 USD. The remaining antibiotics had a higher cost per unit of success, and therefore the results showed that AAC was the best alternative considering this criterion. The therapy that showed a larger percentage of cured patients in RSC was clindamycin (cost per unit of success 666.3 USD); however, the therapeutic alternative with the lowest cost per successful unit was the one based on ciprofloxacin, which dominates gatifloxacin and AAC. CONCLUSION: Ciprofloxacin is a cost-effective alternative for both, RSA and RSC; however, AAC is also a good alternative in RSA when resources are constrained. Sensitivity analysis showed the strength of the base study results.