tions for both patients and providers, yet has received little attention since Part D went into effect. Our objective was to determine the impact of Medicare Part D on MA enrollment. **METHODS:** State-level data from the Centers for Medicare and Medicaid Services (CMS) were used to calculate overall Medicare enrollment (including dual eligibles), enrollment in managed care plans, and enrollment in MA plans with drug coverage (MA-PDs) and stand-alone prescription drug plans (PDPs) from January 2003–June 2006. States were classified as having low, medium, or high penetration based on tertile of penetration for the first quarter of 2003 (1Q03). The effect of Part D on managed care enrollment penetration in states with low, medium, and high penetration was assessed using linear regression. **RESULTS:** Nationwide, MA penetration increased from 14.0% in 4Q05 to 15.3% in 2Q06. MA penetration significantly increased following the implementation of Part D, but only in states which had low Medicare managed care penetration prior to Part D ($p < 0.05$). **CONCLUSION:** New MA enrollees living in areas that historically had little experience with managed care may face interruptions in health care or difficulties accessing care, at least initially. CMS should carefully monitor the health care patterns of new MA enrollees to ensure that beneficiary health is not compromised.

PIH9

PATIENT GENDER AND ASSOCIATED MEDICATION ADHERENCE IN AN OLDER POPULATION WITH CHRONIC DISEASES

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OBJECTIVES: Medication nonadherence is an important problem in older populations, and is affected by numerous factors. The aim of this study was to examine the relationship between gender and medication adherence in older adults with chronic diseases. **METHODS:** A longitudinal cohort study was conducted in older adults (aged >65 years) who completed a health status assessment and were enrolled in a health maintenance organization. The study sample included patient cohorts with four major chronic diseases. Medication Possession Ratio (MPR) was used as a measure of medication adherence in Type 2 Diabetes Mellitus (n = 775 patients), asthma (n = 129 patients), and overactive bladder (OAB) (n = 275 patients). Persistence rate was used as the measure of medication adherence in glaucoma (n = 268 patients). **RESULTS:** For glaucoma patients, males had a significant 0.111-point (22.2% increase over mean) decrease in medication persistence ($p < 0.05$). In male asthma patients, there was a similar 0.13-point (38% increase over mean) decrease in medication adherence as measured by the Med-Total score ($p < 0.05$). A 0.0051-point increase (0.8% increase over mean) in MPR was found in male patients receiving continuous antidiabetic pharmacotherapy ($p > 0.05$). In male OAB patients, there was a 0.025-point increase (6% increase over mean) in MPR for antimuscarinic medications ($p > 0.05$). **CONCLUSION:** This study found significant but unexplained associations between male gender and decreased medication adherence in glaucoma and asthma patients. No significant adherence differences were found between males and females for Type 2 diabetic and OAB patients. This suggests that gender can be a predictor of medication adherence but this effect varies depending on which chronic disease the patient suffers from. Further study of these gender differences is warranted in order to improve medication adherence and aid in disease intervention.

PIH10

BURDEN OF PREMENSTRUAL DYSPHORIC DISORDER ON HEALTH-RELATED QUALITY OF LIFE

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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.

PIH11

QUALITY-OF-LIFE WEIGHTS FOR THE U.S. POPULATION: SELF-REPORTED HEALTH STATUS AND PRIORITY HEALTH CONDITIONS, BY DEMOGRAPHIC CHARACTERISTICS

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OBJECTIVES: Many of the large ongoing national surveys of the US population contain a question that asks for the respondent's self-reported health status: "excellent," "very good," "good," "fair" or "poor." These surveys could be used to conduct cost-utility analyses of health care policies, treatments or other interventions if quality-of-life (QOL) weights for the self-reported health statuses were also available. The objective of this study was to produce nationally representative QOL weights for self-reported health status and for 10 priority health conditions, by a series of demographic variables. **METHODS:** The Medical Expenditure Panel Survey contains the questions from the EQ-5D health status measure. A recent study has calculated time-trade-off-derived QOL weights corresponding to the EQ-5D health states for a large US sample. We use these data to construct QOL weights for the five self-reported health status categories and 10 priority health conditions, by a series of demographic variables. **RESULTS:** Mean and median QOL weights were produced for self-reported health status, the 10 priority

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

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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 (57–75% versus 52%; P = 0.009 and 63–80% versus 54%; P = 0.003). These efficacy results were greatest in the 100 mg DVS group. The treatment satisfaction threshold was 1.64 for daytime hot flushes, 0.20 for the hot flushes severity score, and 0.42 for nighttime awakenings. Statistically significant efficacy outcomes with DVS 100 mg compared with placebo exceeded all treatment satisfaction thresholds. **CONCLUSION:** Among menopausal women in this study, the treatment satisfaction thresholds in vasomotor symptoms reduction over placebo were 1.64 hot flushes per day and about one nighttime awakening every other night. Exceeding these vasomotor symptoms change thresholds indicated that the 100 mg dose of DVS had achieved important and meaningful improvements from the participants' perspective. DVS is an effective option for treatment of vasomotor symptoms associated with menopause.

INFECTION—Clinical Outcomes Studies

PIN1

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

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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/sulfametoxazol (TMP/SMX), amoxicilin/clavulanic acid (AAC) and clindamicin. 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 rapy that showed a larger percentage of cured patients in RSC was clindamicin (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

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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 naïve 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 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