EPS therapies obtained at wholesaler prices in 2001 were used to perform a cost-effectiveness analysis comparing the cost per patient free of EPS between drugs.

RESULTS: Five hundred five evaluable patients were assessed. The average doses were those seen commonly in the clinical setting: 13.5 mg/d (OLAN), 360.5 mg/d (QUE) and 5.3 mg/d (RIS). Tolerability and economic evaluation outcomes for olanzapine (n = 228), quetiapine (n = 43) and risperidone (n = 234) were: 35.8%, 39.5% and 55.1% with EPS (chi²: p < .05 risperidone vs. olanzapine); 35.3%, 18.2% and 43.2% with SD-RAEs (chi²: p < .05 risperidone vs. quetiapine); 74.5%, 13.5% and 53.4% with weight gain (chi²: p < .05 risperidone & olanzapine vs. quetiapine); daily therapy cost was 3.67, 2.72 and 1.96 euros; daily cost per patient without EPS was 5.72, 4.38 and 4.50 euros. EPS and SD-RAEs were dose-related but weight gain was not. SD was more frequent in men. Add-on therapy for EPS was required by 20.3%, 16.4% and 7.1%, respectively of risperidone-, olanzapine- and quetiapine-treated patients. SD and weight changes modified psychiatrist-patient management in only 17.2%, 10.2% and 0.0%, and in 2.1%, 9.0% and 0.0%, respectively.

CONCLUSION: EPS, SD-RAEs and weight changes are common side effects with atypical antipsychotics. Cost per patient without EPS is higher with olanzapine than with risperidone or quetiapine.

ECONOMIC ANALYSIS OF PATIENTS WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER
Swensen A¹, Claxton A¹, Birnbaum H², Greenberg P¹, Marynchenko M³
¹Eli Lilly and Company, Indianapolis, IN, USA; ²Analysis Group/Economics, Cambridge, MA, USA

OBJECTIVE: Attention Deficit Hyperactivity Disorder (ADHD) is a condition that affects both children and adults. Although behavioral aspects of this disorder are well documented, little is known about associated medical costs. This study investigates the extent to which ADHD imposes a financial burden from the perspective of the beneficiary’s employer/third party payer.

METHODS: The data source is an administrative claims database for the employed population of a national, Fortune 100 manufacturer. It includes medical, pharmaceutical, and disability claims for employees, spouses, dependents, and retirees for 1996–1998 (n > 100,000). The research sample consisted of individual patients with one or more medical or disability claim for ADHD (N = 1,308). Resource utilization in the ADHD sample was compared with that of a matched sample of the employees’ overall beneficiary population. The matching criteria were age, gender, state, and employment status.

RESULTS: The analysis included both direct (medical and pharmaceutical) and indirect (disability and sporadic absenteeism) costs. Average annual costs were $2,172 for ADHD patients, and $730 for the matched controls. Total costs for ADHD patients were three times those for the controls. Thirteen percent of all direct and indirect costs associated with ADHD patients could be attributed primarily to the treatment of ADHD. Eighty-one percent of ADHD patients had office visits in 1998, versus forty-eight percent of the matched controls.

CONCLUSION: Based on these findings, resource utilization by ADHD patients is substantially greater than that of individuals without ADHD. Increased health-care costs are due to medical interventions for ADHD and associated co-morbidities. Thus, ADHD is associated with a significant financial burden for employers.

MANAGEMENT AND COST OF A MANIC EPISODE IN BIPOLAR DISORDER— A FRENCH STUDY
Levy E¹, Olié JP²
¹University Paris-Dauphine, Paris, France; ²Sainte-Anne Hospital, Paris, France

OBJECTIVES: Relatively little data exists to estimate the true burden of manic episodes on health-care systems, and information on the therapeutic strategies used is lacking. This study was undertaken to identify the treatment strategies chosen and to assess the cost of treating a manic episode for bipolar patients in a real-world setting.

METHODS: A multi-centre retrospective study over a three-month period. Data were collected from hospital records of patients who had to be hospitalized for a manic episode between 1997 and 1999. Health-care resource utilisation (hospitalization, nursing home, medications and laboratory tests) was assessed, direct costs were calculated, and treatment strategies analysed.

RESULTS: A total of 137 patients’ files (51.8% female, mean age = 35 years) were reviewed. Data on 185 hospitalizations were collected among which 28% of patients had more than one hospitalization. The breakdown of treatment strategies at D30 of hospitalization was as follows: neuroleptic and mood-stabilizer, 64% of patients; neuroleptic alone or in association without mood-stabilizer, 18%; mood-stabilizer alone or in association without neuroleptic, 14%; strategy without mood-stabilizer or neuroleptic, 4%. After discharge, the breakdown of these strategies was respectively as follows: 62%; 14%; 22%; and 2%. The mean number of days spent in hospital was 47 over the study period. On average patients had received 4.9 medications at hospital and 3.4 in the community. The mean direct cost incurred over the three-month study period was 22 297 Euros. The breakdown of the cost per patient for the three-month data period is as follows: hospitalization 98.6%; rehabilitation 0.6% (9 patients out of 137); visits 0.4%; medication 0.3%; laboratory tests < 0.01%.

CONCLUSION: These results confirm that the costs of treating a manic episode are high, and overwhelmingly due to the cost of hospitalization.