oncologists to confirm if the literature descriptions of the modalities were consistent with experience in clinical practice. Draft descriptions were then prepared, and critically reviewed by patients from each of the treatment modalities for not only accuracy and relevance but also comprehensibility. Patients were also specifically instructed in these qualitative interviews to describe the impact of their treatment modalities on their everyday lives, to ensure that the ensuing descriptions captured relevant patient outcomes and were phrased in language used by patients. Finally, interviews were carried out with lay persons to review the descriptions for clarity and comprehensibility.

RESULTS: The three commonly used treatment modalities for CRC were Modified de Gramont, Mayo, and Xeloda. It was decided to describe each modality in terms of efficacy, adverse events, administration procedures, and patient outcomes. For ease of comprehension, patients and lay persons suggested presenting the information in separate sections. Subjects were satisfied that the ensuing descriptions accurately captured the relevant issues and were comprehensible.

CONCLUSION: We have successfully prepared accurate and comprehensible descriptions of treatment modalities and ensuing health states in CRC. These descriptions may be useful in health state preference measurement studies using non-patients as respondents.

PMI4

ASSESSING RESOURCE USE WITHIN ONCOLOGY INDICATIONS: A METHODOLOGICAL APPROACH TO CONDUCTING RETROSPECTIVE DATA ANALYSES

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Reimbursement and other health policy decisions may be highly influenced by analysis of claim-based utilization. Secondary analyses of medical claims data to describe patterns of resource utilization often rely on arbitrarily defined timeframes. In oncology, where treatment is in short defined time periods, both simple use-per-time averaging and illness-episode approaches based on primary diagnosis and treatment may inaccurately estimate resource utilization.

OBJECTIVE: This study examined the variation in utilization of an injectable oncology supportive care agent using three different analytical techniques.

METHODS: Patients with a principal diagnosis of cancer and use of filgrastim were extracted from the 1996–98 Medicare 5% claims database. Patterns of resource utilization were compared with 1) simple use-per-time averaging; 2) illness-episode aggregation; and 3) per-chemotherapy cycle aggregation. Descriptive statistics for the number of days of utilization are reported.

RESULTS: A total of 5,160 patients yielding 2.9 million claims were analyzed. The range of filgrastim resource utilization varied considerably depending on the analysis technique used: simple use-per-time was 1 to 159 days; illness-episode aggregation was 1 to 51 days; and per-chemotherapy cycle aggregation was 1 to 15 days. For all analyses, the medical claims data do not provide adequate rationale for use or days of utilization, and therefore this database has limited value as a guide to future decision-making. In addition, the analysis was limited in the ability to accurately identify chemotherapy regimens; differentiate prophylactic vs. treatment use of supportive agents; and in describing oral chemotherapy use, dose delays and reductions, and reasons for chemotherapy alterations.

CONCLUSION: Resource utilization in oncology is highly influenced by the data source and the analysis method chosen, which may not allow for an accurate understanding of practice patterns. Only by understanding these limitations in specific disease areas can the medical decision-making be improved leading to better patient outcomes.

PMI5

FACTORS FOR THE VARIATION IN THE PREVALENCE OF ARTERIAL PERIPHERAL DISEASE—STUDY IMPLICATIONS FOR OUTCOMES RESEARCH

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Prevalence of peripheral arterial disease (PAD) has been constantly grown over the past decades. However, inconsistent data on PAD prevalence from published literature were limited in use for either research or disease management.

OBJECTIVES: The purposes of this review were to summarize published PAD prevalence and to identify factors that may cause the variation in PAD prevalence.

METHODS: English-language studies published between 1980 to December 2001 were identified through a MEDLINE search.

RESULTS: Thirty-one studies on PAD prevalence were identified. The present review showed that the prevalence of PAD varied and it was highly dependent on the definition of clinical presentations. Additional factors for the variation included type, sensitivity and/or specificity of diagnostic tests for screening and the distribution of risks for PAD including age, male gender, smoking, diabetes and dyslipidemia. The review showed that the prevalence of PAD varied ranging from 1.2% in general population to 29% in high-risk patients. After adjusting for age, gender and clinical presentation, the overall PAD prevalence and the prevalence with intermittent claudication were 8.7% to 26.5% and 1.6% to 2.9% respectively. Prevalence of PAD was often higher (2 to 7 times) in studies using a combination of noninvasive tests, patient reported history and physical examinations for diagnosis than that in those studies using only patient history plus
ESTIMATING THE BENEFITS OF ANTIHYPERTENSIVE THERAPY: AN ASSESSMENT OF PULSE PRESSURE
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OBJECTIVES: Recent analyses suggest that pulse pressure is an important and independent risk factor for cardiovascular disease. Accordingly, pulse pressure may also be an important variable for inclusion in economic analyses of hypertension therapy. We therefore analyzed the relationship between pulse pressure and cardiovascular events after adjustment for other risk factors to determine if pulse pressure is an explanatory variable in the treatment of hypertension. We then evaluated the importance of pulse pressure as an explanatory variable in the treatment of hypertension.

METHODS: Using multivariate analyses and data from the Lipid Research Clinic Cohort, we examined the association between specific blood pressure measures and cardiovascular death after adjustment for age and other risk factors. We then compared the goodness of fit (GOF = [observed events–expected events]/expected events) of various Markov models to forecast the results of randomized clinical trials of hypertension therapy using single blood measures or combinations of measures.

RESULTS: Pulse pressure is a strong univariate risk factor for coronary and cardiovascular death. Both pulse pressure and diastolic blood pressure were independent (p < 0.05) risk factors with a significant negative interaction between increasing age and diastolic blood pressure and a positive but non-significant pulse pressure x age interaction. In Markov model simulations, the model including diastolic and pulse pressure better approximated (GOF = 91) the observed outcomes in five clinical trials compared to either systolic, diastolic or pulse pressure alone (GOF = 208, 375, 706 respectively).

CONCLUSION: Pulse pressure is a significant independent risk factor for cardiovascular events that increases in relative importance with increasing age. When pulse pressure is added to a Markov model with diastolic blood pressure the results of clinical trials are more accurately forecasted. Economic analyses of hypertension therapy may be enhanced by considering blood pressure changes other than only systolic or diastolic in isolation.