initiation of a new DMARD within 60 days of the discontinuation date of the index biologic; intermittent use of the index biologic; and 6 months of treatment gap, ‘step-down’ - adding a new DMARD for ≥28 consecutive days. Numbers are reported in pairs with ETN first and ADA second. RESULTS: Over the 12-month study period, majority of PaA patients newly initiated ETN/ADA (N=2037/2217) had ≥ 1 therapy change (65.3%/65.4%) with a median time to change: 115/112 days. Among patients initiated on ETN/ADA (N=1410/1490), 60.7%/73.5% patients remained on the index mono therapy, 12.1%/15.6% patients discontinued the treatment, 18.2%/ 14.7% patients had intermittent treatment, 7.0%/11.4% switched to another mono therapy, and 21.9%/21.6% stepped up to combo therapy. Among patients initiated on ADA/ETN in combination with an oral DMARD, 21.4%/26.8% remained on the original combo therapy, 77.5%/72.7% ‘stepped down’ to a mono therapy, and very few patients discontinued therapy (0.5%/0.1%) or adopting intermittent biologic therapy (0.6%/0.3%). CONCLUSIONS: This study suggests that most of the PaA patients newly initiated on ETN or ADA have a therapy change over the first year.

URINARY/KIDNEY DISORDERS - Clinical Outcomes Studies

PUK1 A SWEDISH PROSPECTIVE OBSERVATIONAL STUDY TO EVALUATE THE IMPACT IN QUALITY OF LIFE AMONG PREVIOUSLY UNTREATED PATIENTS RECEIVING THEIR FIRST PRESCRIPTION OF SOLIFENACIN. (SPOQ-STUDY)
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OBJECTIVES: To evaluate in daily clinical practice possible changes in perceived quality of life (QoL) in patients treated with solifenacin and also to investigate whether the treatment had an impact on the use of incontinence pads. METHODS: This non-interventional study consisted of one visit at the study centres per patient and two follow-up questionnaires (13-item QoL and 6-item bother scale, OAB-q SF and 6-item bother scale of the OAB-q SF) at 3 and 6 months, analyzed by the patients. RESULTS: A total of 232 patients were included in the study at 35 centers in Sweden. Sixty patients participated at baseline only. The age of patients ranged from 25 to 87 years (mean 64 years). One hundred and sixty-seven patients (97.1%) were women. PaA patients were at higher risk of occurring MRPs. Pharmacists intervened 17.91% of the MRPs and also kept monitoring 58.2% of the total MRPs. Most MRPs (48.4%) were pharmacokinetic, followed by pharmacodynamic (32.6%) and non-compliance (20%). The monitoring for drug interactions is highlighted in the study. CONCLUSIONS: Patients with renal failure have different patterns of MRPs. Pharmacists should be more careful when evaluating these patients’ medications.

URINARY/KIDNEY DISORDERS - Cost Studies

PUK4 A COST-COMPARISON ANALYSIS OF TREATING OVERACTIVE BLADDER (OAB) PATIENTS EXPERIENCING TREATMENT FAILURE TO ECULIZUMAB, TOLTERODINE OR SOLIFENACIN IN DAILY CLINICAL PRACTICE IN SPAIN
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OBJECTIVES: To determine the cost implications of different treatment options for patients with OAB that have failed or are intolerant to first line treatment. METHODS: A retrospective study was designed using primary care electronic medical records from three towns in Spain. Records of patients who initiated OAB therapy between 2008 and 2010 and with a follow-up of at least 52 weeks were retained. Patients 18 over both genders with an OAB diagnosis [ICD-9-CM 596.51] and a new prescription of solifenacin, tolterodine or solifenacin were included in the study. parachute clinical trials were compared using a common denominator, the number of patients over 18 of both genders with an OAB diagnosis [ICD-9-CM 596.51]. All patients were treated with solifenacin, 952 with solifenacin and 717 with tolterodine. Respectively, 17%, 22% and 25% of subjects used absorbes for urinary incontinence, complementary/diagnostic tests and constipating medications related along with cost of antimuscarinics were analyzed (NHS perspective). Comparisons between antimuscarinics were adjusted by location, age, sex, time since diagnosis, co-morbidity burden and medication possession ratio (medication/time), and were compared using univariate linear general model with bootstrap (1000 re-samples) bias correcting methods to calculate 95% confidence intervals. RESULTS: A total of 1,971 records (58.3% women, 70.1 [SD: 10.6] years) were analyzed, 302 treated with solifenacin, 952 with solifenacin and 717 with tolterodine. Respectively, 17%, 22% and 25% of subjects used absorbes during the study (p=0.014). Adjusted mean health care costs (95% bootstrap CI) were significantly lower with tolterodine treatment ($1639 [1567; 1710] compared with solifenacin $1800 [1780; 1830]; p=0.002). All medical visits costs were also lower with tolerodine ($433 [411; 457] than with solifenacin $533 [515; 552]; p<0.001) or tolterodine ($563 [539; 585]; p<0.001). Drug costs due to co-morbidities associated with OAB were $16 [1910; 2580] compared with $18 [1780; 1969] for solifenacin ($305 [274; 338]; p=0.002) or tolterodine ($335 [306; 366]; p<0.001). CONCLUSIONS: Treatment of OAB with solifenacin in clinical practice in Spain was a cost-saving therapy from the NHS perspective as compared to solifenacin or tolterodine.

PUK5 EMPLOYMENT RATES AND INDIRECT COSTS IN PATIENTS WITH END-STAGE RENAL DISEASE: DIFFERENCES BETWEEN MODALITIES OF RENAL REPLACEMENT THERAPY
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OBJECTIVES: The present study aimed to compare the indirect costs associated to morbidity in end-stage renal disease patients undergoing one of the following alternatives of renal replacement therapy (RRT): Hemodialysis in a specialized center (HD), automated peritoneal dialysis (APD), continuous ambulatory peritoneal dialysis (CAPD), and renal transplant (TX). METHODS: An analysis on indirect costs from morbidity on RRT was implemented, following the Human Capital Theory. An epidemiological, multicenter, cross-sectional study was conducted. A total of 243 patients in working age were included (32 CAPD, 46 APD, 83 HD (29.9%) and 93 TX). The potentially most important 5 parameters that were monitored for were being a part of the labor productivity (LPC) for the year 2009 and the total cost of FPV (FPVlct) until retirement were estimated. All the estimations were adjusted by age, sex and different activity rates (obtained from the Spanish National Institute of Statistics). RESULTS: Indirect employment rates of 0%, 3%, 5% and 10% were also considered. Chi-2 tests of Krukal-Wallis or Mann-Whitney U (Bonferroni correction) statistics were used to compare socio-demographic and clinical variables. Due to its skewed distribution, non-parametric analysis (a bootstrap confidence intervals of differences in costs calculated following the simple bias-corrected percentile method -1,000 bootstrap estimates) - was computed to highlight differences in costs. RESULTS: No significant differences were found in age or sex between groups (p>0.05). The FPVlct were: