OBJECTIVE: Assess diabetes incidence for individuals treated with antipsychotics. METHODS: Medical/pharmacy claims from a large insured population were analyzed to identify 5631 individuals initiated on typical (n = 2326) or atypical (n = 3305) antipsychotics between October 1, 1996 and December 31, 1998; had no antipsychotic use; had no diabetes diagnosis and/or antidiabetic use in the year prior. Patients were followed to the first event including: new-onset diabetes; antipsychotic augmentation/switch/discontinuation; insurance disenrollment; end of the data. Diabetes was defined as receiving two diabetes diagnoses (ICD9-CM: 250.xx) and/or one antidiabetic prescription. Additionally, incidence of treated diabetes (received antidiabetic prescription) was examined. Cox proportional hazard models were used to compare the hazard ratios (HR), controlling for potential confounding factors. RESULTS: Crude diabetes incidence was 1.76% and 1.97% for typical and atypical cohorts, respectively (2.04% and 1.95% for olanzapine- and risperidone-treated patients, respectively). Rates of treated diabetes were 1.72% for typical and 1.94% for atypical cohorts; 1.95% for both olanzapine and risperidone cohorts. Among the treatment groups, adjusted HR (95% confidence interval): atypical-versus-typical: 1.13 (0.75–1.69); olanzapine-versus-typical: 1.14 (0.67–1.95); risperidone-versus-typical: 1.12 (0.72–1.75); and olanzapine-versus-risperidone: 0.96 (0.56–1.65). Similar results were observed for treated diabetes incidence. CONCLUSION: Diabetes incidence was not statistically significantly different for atypical versus typical, although typical-treated patients had numerically lower incidence. There was no significant difference between olanzapine and risperidone.

OBJECTIVES: To compare treatment outcomes, by the Brief Psychiatric Rating Scale for Children (BPRS-C), and length of stay (LOS) for a group of child and adolescent psychiatric inpatients who were prescribed an atypical antipsychotic (AA) to those not prescribed an AA at discharge. METHODS: Data was collected from 48 facilities across the United States between July, 1999 and June, 2003. Descriptive statistics, ANOVA, and ANCOVA were used to compare differences between and within a group that was prescribed an AA (risperidone, olanzapine or quetiapine) (n = 1131) and a group that had not been prescribed AA at discharge (n = 1741). RESULTS: Inpatients were between 4–17 years old. Most patients were Caucasian, male, suffered from their disorders between 2–3 years, and lived at home with family prior to admission. At admission, the AA treatment group showed greater difficulty with respect to BPRS-C overall score (p < 0.001); however at discharge, patients given AA showed greater improvement in BPRS-C subscores of behavior problems, thinking disturbances, and psychomotor excitation (p < 0.03), but less improvement in the depression subscore than patients given no antipsychotic (p < 0.02). Average daily dosage at discharge was 2.3 mg for risperidone, 156.3 mg for quetiapine, and 9.6 mg for olanzapine. After adjusting for covariates, AA patients had a longer LOS (26.4 vs. 22.4 days) than patients given no antipsychotic (p = 0.017). AA patients treated with risperidone had significantly shorter LOS (17.3 days) than those treated with quetiapine (24.3 days) or olanzapine (28.1 days) (p = 0.024). CONCLUSIONS: Child and adolescent inpatients receiving AA had more significant emotional and behavioral disorders at admission than those not prescribed an AA. The AA treatment group showed greater improvement in behavior problems, thinking disturbances, and psychomotor excitation outcomes than patients given no antipsychotic, but less improvement in depressive symptoms. Among AA treated patients, LOS was significantly shorter for inpatients treated with risperidone.

PMH8

SWITCHING & DISCONTINUATION OF SERTRALINE, PAROXETINE AND CITALOPRAM THERAPY
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OBJECTIVES: Patient adherence is critical for successful management of mental illnesses. This study compares adherence rates across branded selective serotonin reuptake inhibitors. METHODS: This retrospective cohort study used an administrative database between January 1, 1999 and June 30, 2002. Adherence status was categorized into persistence, switching and discontinuation. Persistence was defined based on the days supply, with a minimum of 15 days to refill. Survival analyses were conducted. Age, gender, and co-payment were included as covariates in Cox proportional models. Sensitivity analyses were performed to determine the sensitivity of the algorithm for determining adherence. RESULTS: Compared with sertraline patients (N = 3598), those on paroxetine (N = 5204) had lower persistence rates (23.8% vs. 26.0%, P = 0.0093), higher switching (3.6% vs. 3.3%, P = 0.5076) and discontinuation rates (72.7% vs. 70.7%, P = 0.0258). Survival curves showed that the persistence rates for sertraline patients were significantly greater than for paroxetine (P < 0.05, Log-Rank and Wilcoxon tests), while similar to those for citalopram patients (N = 4131). Age and gender were independent predictors of persistence, while co-payment was not. These findings were consistent across a broad variety of definitions of persistence by varying the allowed time to refill. CONCLUSIONS: Paroxetine patients were significantly more likely to discontinue therapy than either sertraline or citalopram patients.