ies involving symptomatic patients defined as modified Medical Research Council (mMRC) score ≥2 or COPD Assessment test (CAT) score ≥10 presenting common symptoms of COPD were included. Studies focused on cost of illness and resource use in adult symptomatic COPD patients were included. Studies meeting the eligibility criteria were appraised using Drummond checklist. RESULTS: Database searches yielded 4491 references which resulted in 74 relevant studies after two levels of screening. All the included studies were of adequate reporting quality with study objective and competing alternatives being defined clearly. The annual direct medical cost of COPD ranged from US$521 in France to US$4159 in the United States. Physician consultations were the most frequently utilised resource, followed by ER visits and hospitalisations. The composition of direct costs differed between countries, with more than 50% of the direct costs resulting due to inpatient admissions. In Canada, Italy, Spain, the UK, and the United States and almost 50% due to regular prescribed medicines in The Netherlands. The mean annual societal costs ranged from US$1023 in The Netherlands to US$6546 in the United States. The annual direct medical cost of COPD patient was higher in patients with severe levels of dyspnoea and symptoms, frequent exacerbations, comorbid conditions, low educational status and former smokers. Economic burden of lost productivity was the highest in the U.S and the lowest in Italy. Lost productivity accounted for 67% of annual societal costs per patient were higher in patients with severe COPD, higher costs ranged from US$1023 in The Netherlands to US$5646 in the United States. Physician consultations were the most frequently utilised resource, accounting for 21% of COPD management of symptomatic COPD is associated with a substantial economic burden, especially in the developed nations of Europe and North America.

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OUTPATIENT DIRECT COST OF COPD IN A THIRD LEVEL HOSPITAL: PATIENT PERSPECTIVE
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OBJECTIVES: Chronic Obstructive Pulmonary Disease (COPD) is a major worldwide cause of morbidity and mortality. COPD elderly patients spend a large amount of money; elderly population is rapidly increasing due to population ageing. COPD prevalence in adults ≥ 40 years is 7.8% in Mexico (CORTIXD) and 10.8% in the World (LIP). Information about out-of-pocket expenses of COPD patients in Mexico. The objective is to estimate direct costs of COPD from patient perspective in a third level hospital in Mexico. METHODS: A pool was developed from August to November of 2013 in a third level hospital in Mexico. All COPD patients ≥ 40 years old attending this hospital and meeting the inclusion criteria were included. We calculated the average cost of medical consultation, clinical test, travel, gasoline and food from outpatients and stratifying by severity. All cost were transformed in US Dollars of 2013. RESULTS: We interviewed 242 outpatients. According GOLD criteria the patients were classified as: mild (n = 105), severe (n = 38), and very severe (n = 98). Mean age of patients was 71.7 years, 141 (58.3%) were men and 133 (54.9%) had social security. Annual total costs for mild, moderate, severe and very severe were $64,5, $99.9, $130.7 and $138.4, respectively. CONCLUSIONS: The model estimated that in current confirmed asthma and COPD diagnosis rates in the UK, with the proportion of patients receiving FDCs based on available market research data. Costs of inhalers, scheduled care and unscheduled health care events were taken from publicly available sources in the UK. Frequency of poor inhalation technique measured through the occurrence of critical inhaler errors—was common with existing inhalers, and may contribute to the economic burden of disease management by increasing health care resource use. We have developed an economic model to evaluate the clinical and economic burden of asthma and COPD in the UK, and assess the impact of inhalation technique with ICS + LABA FDCs on costs and resource use. METHODS: The eligible adult patient population was based on current asthma and COPD diagnosis rates in the UK, with the proportion of patients receiving FDCs based on available market research data. Costs of patients receiving FDCs based on available market research data. Costs of inhalers, scheduled care and unscheduled health care events were taken from publicly available sources in the UK. Frequency of poor inhalation technique measured through the occurrence of critical inhaler errors—and the associated increased risk of unscheduled health care events were taken from a large (n = 1,664) cross-sectional, observational study in Italy. RESULTS: The model estimated that 1.3 million adults with persistent asthma and COPD receive an ICS + LABA FDC in the UK, annually, of which, 366,000 demonstrate poor inhalation technique. Total direct costs were estimated to be £37.5 million, with costs of unscheduled health care events accounting for £137 million. Poor inhalation technique with ICS + LABA FDCs was estimated to be responsible for 11.8% of unscheduled health care costs, equating to £6.2 million annually. CONCLUSIONS: The clinical and economic burden associated with poor inhalation technique in asthma and COPD is considerable in the UK. Novel inhalers, which improve inhalation technique, may offer clinical and economic benefits in the management of asthma and COPD.

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WITHDRAWN