grouped by gender and age. The study was conducted from the societal perspective using Year 1996–1999 prices, adjusted to year 2000 by CPI. Life expectancies were adjusted for QOL using the Index of Well-Being. Probabilities and prices were collected from the literature, the SEER program, National Vital Statistics, and BLS. The model considered H. pylori reinfection and gastric carcinogenesis risk over time. One-way sensitivity analyses were conducted on critical or uncertain parameters and threshold analyses on pivotal parameters. RESULTS: The incremental cost-effectiveness ratio (ICE) for pooled patients (both genders) decreases with age from $3,612 per quality adjusted life year (QALY) saved at age 40–44 to the minimum of −$200 (dominant) per QALY saved at age 65–70. After age 70, the ICE increases with age. Females have higher ICEs than males in every age subgroup. The ICE was sensitive to discount rate, relative risk of gastric cancer (GC) in H. pylori infected patients, cost of treating GC, and cost of empiric antisecretory therapy, but not to the reinfection rate or infection rate of H. pylori, the change of the utility rate of GC and the one-year utility of dyspepsia patient under empiric antisecretory therapy. CONCLUSIONS: Taking $50,000/QALY as the societal ICE threshold, H. pylori screening and eradication is cost-effective for both genders at any age group, especially for male patients at older ages. Better estimates are needed for certain key parameters such as the relative risk reduction of GC with H. pylori eradication.

PG13

A PROSPECTIVE, RANDOMIZED COST ANALYSIS OF MEPERIDINE AND MIDAZOLAM VERSUS PROPOFOL FOR COMPLEX UPPER ENDOSCOPY PROCEDURES
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OBJECTIVES: Meperidine/midazolam (M/M) and propofol (P) are clinically effective alternatives for sedation during endoscopic procedures. Propofol has a higher acquisition cost, but may be associated with cost savings due to shorter duration of post-procedure care. The objective of this project was to compare the costs associated with complex upper endoscopic procedures (ERCP/EUS) in subjects who received either M/M or propofol. METHODS: Subjects scheduled for ERCP/EUS were randomized to receive M/M or P during the procedure. A blinded observer assessed time to recovery using a standard 10-point postanesthesia recovery score (PARS) every 15 minutes. Once a PARS score of 10 was reached, the subject terminated and the subject was discharged from the recovery ward. The cost of drug (source: Redbook), an anesthetist for the propofol group (source: Bureau of Labor Statistics), recovery room personnel costs (source: Bureau of Labor Statistics), and overhead costs were compared from the institutional perspective. A sensitivity analysis was performed by assuming generic drug, a nurse anesthetist, and licensed practical nurse (LPN) care in the recovery ward. RESULTS: 33 and 31 subjects were randomized to receive M/M and P, respectively. There were no significant differences detected between the groups in age, gender, case severity, or procedure duration. P group subjects had a significantly shorter post-procedure recovery time (19 minutes) compared with M/M group subjects (71 minutes, p < 0.001). Subjects in the M/M group cost an average of $65 per case, while P group subjects cost an average of $144 per case (p < 0.001). The sensitivity analysis resulted in an average cost of $77 per case in the P group and $34 in the M/M group (p < 0.001). CONCLUSIONS: Subjects in the P group had a significantly shorter post-procedure recovery time but this did not result in cost savings compared with subjects treated with M/M.

PG14

HEALTH-RELATED QUALITY OF LIFE (HRQOL) DATA REVEAL DIFFERENCES AMONG CLINICAL “RESPONDERS”
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OBJECTIVES: Treatment effects are often evaluated by comparing groups in terms of the proportion of “responders”, i.e., patients who achieve some prospectively defined outcome. In the absence of additional data, it is assumed that responders in different treatment groups achieve comparable benefits and therefore that the treatment benefit is fully described by the responder rates. This study compared the HRQOL changes of responders in two treatment groups. METHODS: In two identical randomized, double-blind, placebo-controlled studies (S3BA3001; S3BA3002) in women evaluating 12 weeks of treatment with alosetron 1mg BID, patients completed the Irritable Bowel Syndrome Quality of Life Questionnaire (IBSQOL) at baseline and at the final treatment visit. A patient was classified as a responder if she achieved adequate relief of IBS pain and discomfort on at least 2 of 4 weeks for all 3 months. This post-hoc analysis compared responders from the two treatment groups in terms of IBSQOL change from baseline scores at the final visit using analysis of covariance. The analysis focused on patients with diarrhea-predominant IBS. RESULTS: Our analyses included 154 patients (96 alosetron and 58 placebo) in S3BA3001 and 172 (110 alosetron and 62 placebo) in S3BA3002. Compared with placebo responders, those in the alosetron group had significantly higher (p < .05) scores on 5 of 9 IBSQOL scales (sleep; energy; physical functioning, food and role-physical) in S3BA3001 and on 4 scales (sleep, energy, food and social functioning) in S3BA3002. CONCLUSIONS: Adequate relief responders in the alosetron group experienced significantly greater HRQOL improvements relative to placebo group responders. This suggests that treatment benefits may be underestimated when described only in terms of the additional proportion of responders. Reporting HRQOL dif-