OBJECTIVES: To investigate patterns of therapy, health care utilization, and health care costs among PAH patients initiating therapy with sildenafil in a real-world setting.

METHODS: Patients aged ≥18 years with evidence of PAH (ICD-9-CM diagnosis codes 416.0, 416.8) and ≥1 claims for sildenafil between June 1, 2005, and September 30, 2007, were identified from a large administrative health care claims database. Patients with ≤6 months of pretreatment data were excluded. Patients were followed from index date (first noted sildenafil claim) until health plan disenrollment or end of study (follow-up). Patterns of therapy with sildenafil were examined, including numbers of prescriptions and associated therapy-days and compliance. The latter was measured using medication possession ratio (MPR, ratio of total therapy-days to total days of follow-up). For the subgroup of patients with ≥6 months of follow-up data, health care utilization and costs were compared between the 6-month period preceding and following the index date. RESULTS: Of 851 PAH patients identified who began therapy with sildenafil and met study inclusion criteria (mean age: 53 years; 69% women), 32% had comorbid lung conditions and 17% connective tissue disorders. Over a mean duration of follow-up of 423 days (median, 357 days), patients averaged advanced platelet aggregation inhibitors the drug cost amounted to less than 3% of the total drug costs. For those patients who had at least one health care visit and who were discharged at least one in-patient stay, 18,211 had at least one out-patient visit, and 28,432 had at least one health care visit during 2007–2008 were studied (iohexol: n = 135,619). Propensity score weighted and multivariate logistic regression analyses were performed. Between the groups (6.2–6.3 days), iohexol was associated with a significantly lower risk (P < 0.001) compared with either iopamidol ($23,482) or ioversol ($23,484) and with a significantly lower risk (P < 0.001) compared adjusted hospitalization cost post-procedure ($10,512) compared with either iopamidol ($11,393) or ioversol ($11,187). CONCLUSIONS: In this large cohort of hospitalized patients, in-hospital HD rates were similar between invasive cardiovascular catheterization procedures with LOCM. The risk of HD was comparable with iohexol and ioversol, while iopamidol was associated with a significantly higher risk. While in-hospital mortality rates, LOS, and all-cause 30-day readmission rates did not differ significantly between the 3 LOCM, iohexol was associated with significantly lower cost.

OBJECTIVES: To investigate the impact of the metabolic syndrome on health care cost among South African patients accounted for $7,921,831.10 in 2005, compared to $9,209,773.29 in 2006, $7,980,931.85 in 2007 and $8,515,349.53 in 2008. These costs represented 2.76% (N = 287,538,709.70) of all claims during 2005, compared to 3.18% (N = 239,314,629.60) of claims in 2006, 3.38% (N = 273,086,933.30) in 2007 and 3.87% (N = 228,414,319.80) in 2008. Private insurance had a 90.9% (N = $7,921,831.10) towards the treatment of patients with metabolic syndrome in 2005, compared to 89.92% (N = $9,209,773.29) during 2006, 89.50% (N = $9,780,931.85) in 2007 and 87.17% (N = $8,515,349.53) in 2008. Patients paid on average $68.15 ± 106.18 (median $17.59) out-of-pocket for levos in 2005, compared to $77.21 ± 110.54 (median $15.30) during 2006, $80.42 ± 98.43 (median $49.15) in 2007 and $82.76 ± 96.64 (median $52.66) in 2008. CONCLUSIONS: Results show that the costs associated with the metabolic syndrome contributes significantly towards the annual expenditure of the South African PBM. Private insurers carry most of this burden, although out-of-pocket expenses for patients show an increasing trend.

OBJECTIVES: To determine the therapeutical compliance in subjects with amlodipine and simvastatin substitution from mark to generic. Secondary objective: to know the professional and patient opinion about its use. METHODS: Before-after design with control group, realized revision of the medical records, in six centres of primary care. Participants: Patients ≥40 years initiating treatment of mark drug (initial period) and after that had a substitution by generic (final period), between January 2003 and June 2009. Study groups: arterial hypertension (amlodipine) and Dislipemia (simvastatin). Main measures: Co-morbidity, compliance, treatment-time, Satisfaction and patient’s opinion about its use.

RESULTS: A total of 1232 patients. Groups 49.5% amlodipine; 50.5% simvastatin. Average age: 72.4 years; women 48.9%. The ones treated with amlodipine (comparing periods); show a better compliance (65.8% vs. 61.3%; p = 0.037) and arterial pressure control (48.3% vs. 45.8%; p = 0.039) with mark drugs. With simvastatin, was 62.8% vs. 58.4% = 0.041 (cholesterol control: 66.5% vs. 80.6%; p = 0.032) respectively. Interviewed doctors: 73.6% prescribe generic and a 59.2% believe that both have the same efficacy. Interview patients: a 79.8% (Cl 74.3–85.3%) accepted substitution; a 55.3% (Cl 48.5–62.1%) received the appropriate information and 61.5% do not carry problems with the medicine homoeopathy.

CONCLUSIONS: In patients with amlodipine/simvastatin substitution from mark to generics, it was observed less substitution compliance light, with minor consecution of control objectives. The realized interviews (professional/patients) reaffirm the results.

METHODS: This was a retrospective longitudinal descriptive database study of the utilization of health care of patients from the South-West region of Sweden (1.5 million inhabitants). All patients who were dispensed platelet aggregation inhibitors, excluding heparin (NO5AC) during 2007 and who had a cardiovascular principal diagnosis (chapter 9, ICD-10) were included in the study. Only costs related to cardiovascular care (i.e. visits with a cardiovascular diagnosis) were included. RESULTS: A total of 46,742 patients had at least one dispensed platelet aggregation inhibitor and at least one cardiovascular related health care visit during 2007 in the South-West region of Sweden. A total of 15,779 had at least one in-patient stay, 18,211 had at least one out-patient visit, and 28,432 had at least one primary care visit. The total costs of in- and out-patient care, primary care, and of platelet aggregation inhibitors, excluding heparin was 1.5 billion SEK. The greatest cost contributor was in-patient care, a total of 1.2 billion SEK, 74,501 SEK per patient in in-patient care. The total cost for out-patient care was 98 million SEK, 5371 SEK per patient. The total cost for primary care was 92 million SEK, 3223 SEK per patient. The total drug cost was 43 million SEK, 912 SEK per patient. CONCLUSIONS: For those patients who had at least one health care visit and who were dispensed platelet aggregation inhibitors the drug cost amounted to less than 3% of the total annual costs. In-patient care represented as much as 80% of the total annual costs.

CONCLUSIONS: In-hospital mortality rates were significantly lower (P < 0.001) compared with either iopamidol ($23,482) or ioversol ($23,484) and with a significantly lower risk (P < 0.001) compared adjusted hospitalization cost post-procedure ($10,512) compared with either iopamidol ($11,393) or ioversol ($11,187). CONCLUSIONS: In this large cohort of hospitalized patients, in-hospital HD rates were similar between invasive cardiovascular catheterization procedures with LOCM. The risk of HD was comparable with iohexol and ioversol, while iopamidol was associated with a significantly higher risk. While in-hospital mortality rates, LOS, and all-cause 30-day readmission rates did not differ significantly between the 3 LOCM, iohexol was associated with significantly lower cost.

OBJECTIVES: To investigate in-hospital hemodialysis (HD), length of stay (LOS), mortality, and costs following use of low-osmolar contrast media (LOCM) in patients undergoing invasive angiographic catheterization procedures. METHODS: This retrospective analysis used the Premier Perspective database, which contains patient-level data. In-patient adults without prior HD who underwent invasive angiographic catheterization procedures with LOCM during 2007–2008 were studied (iohexol: n = 36,118, iopamidol: n = 36,118, ioversol: n = 135,619). Propensity score weighted and multi-variate logistic regression analyses were used. RESULTS: In-hospital HD rates were low after exposure to any of the 3 LOCM (0.9% iohexol, 1.0% iopamidol, 1.0% ioversol), Risk of HD did not differ between iohexol and ioversol, but ioversol demonstrated increased risk of HD compared to iohexol (adjusted Odds Ratio [OR]= 1.17, 95% CI 1.02–1.35) and iopamidol (adjusted OR 1.17, 95% CI 1.02–1.34). For in-hospital mortality (2.1% iohexol, 2.3% iopamidol, 1.9% ioversol), no between-group differences were statistically significant. Similarly, all-cause 30-day readmission rates (10.8% iohexol, 10.4% iopamidol, 10.6% ioversol) did not differ significantly between the groups. Contrast-induced acute kidney injury-related 30-day readmission rates were 0.2% in all 3 groups. There was no significant difference in the mean adjusted LOS between the groups (6.2–6.3 days). Iohexol was associated with a significantly lower (P < 0.001) mean adjusted initial hospitalization cost ($21,591) compared with either iopamidol ($23,482) or ioversol ($23,484) and with a significantly lower (P < 0.001) mean adjusted initial hospitalization cost post-procedure ($10,512) compared with either iopamidol ($11,393) or ioversol ($11,187).