primary care (range: 1%–9.4%) than in general hospitals (range: 5.8%–43.3%), and highest in specialist nephrology settings (range: 36.0%–97.6%). Also, prevalence rates increased with the CKD stage (2-12: 14.1%–27.9%; 3: 25.5%–91.1%; 4: 36.0%–85.5%; 5: 97.6%). The cost of managing anaemia per patient varied across studies from $2,616 (2006–2007 Great British Pounds; GBP) to $3,740 (2006 GBP) in the UK, to €5,613 (2005–2006 EUR) in France, to $14,000 (2005 USD) in the United States. Overall cost of managing anaemia was highest in patients with CKD Stage 3 compared with other stages (I: €4,162,056 vs. 4-5: €4,233,288, 2006-2007 GBP). Another study reported higher costs per patient per annum for individuals with lower haemoglobin (HB) levels (HB <12 g/dL: $2,418; HB <6 g/dL: $13,005; cost year not reported). Among patients with CKD, those with anaemia were more likely to be hospitalised (61% vs. 50% of those without anaemia). CONCLUSIONS: Anaemia is a highly prevalent condition in CKD across different healthcare settings, and the evidence available suggests it is associated with a substantial economic burden.

OBJECTIVES: To estimate health and social care resource use in treating individual patients with FXS in Canada and the United Kingdom. FXS is the most common inherited form of intellectual disability (ID) worldwide; however, its impact on resource use is not well documented. METHODS: Delphi panels were formed to generate consensus-based estimates of resource use. Panels consisted of 2 (FXS) and 7 (panelists) experts on FXS and a questionnaire developer obtained to develop estimates from each panelist by 2 age groups, 2 severity levels and 24 service types for each of 9 items from the Aberrant Behavior Checklist (ABC). The resource use was assessed by the caregivers of individuals with ID. A factor weight was estimated to differentiate costs by gender and a self-declared confidence score (1–5) was reported for each ABC item. Mean total service counts and coefficients of variation (CV) were calculated to assess variation across and within panelists in each country. Original results were reviewed with panelists in a facilitated group discussion after which the questionnaire was repeated. Final data were based on the second round of estimation. RESULTS: Credible and validated estimates were generated through group discussion and refinement of initial estimates for patients with FXS.

OBJECTIVES: To gain an understanding of the impact of bariatric surgery on the current medical management of obese patients. METHODS: The EGB database is a 1/97 representative sample (around 600,000 individuals) of the national claims database. The database included medical and non-medical costs and resources significantly reduced from $46,715 vs. $22,978, and fewer visits to the healthcare system. A cohort of patients was constituted with a 2-year follow-up before and after the index procedure date (T). Reimbursed medical consumption over this 4-year period was recorded and presence of comorbidities identified. Credible and validated estimates were generated through ICD-10 coding, reimbursement of specific drugs or procedures. RESULTS: A total of 1703 obese patients met the inclusion criteria. A decrease in healthcare costs on average of 34% (€10,259 of the 4-year treatment period) and a gain of 2.7 years in life expectancy were observed. The impact of pain on health care and non-health care resources utilization accounted for a greater impact on the economic burden of that condition.

RESULTS: The patients with drugs associated with a higher reduction of pain intensity will have a greater impact on the economic burden of that condition. Secondary economic analysis based on data from a multicenter, observational and cross-sectional study was performed in France (cost year not reported). One study reported that the overall cost of bariatric surgery on medical consumption. Additional research with longer follow up could better capture the benefits of bariatric surgery on medical consumption. The treatment strategy included: 1) 2G TKI-resistant, 2) 2G TKI-intolerant if imatinib is not clinically appropriate, or 3) with T315I mutation. Eligible patients received treatment sequences including 2 TKIs and ponatinib in the ponatinib arm and 2 TKIs only (without Mcyr) in the Mcyr arm. Patients were switched to the next therapy line after Tki options were exhausted, then to best supportive care. MCyr rates for 2G TKI or ponatinib were estimated from clinical trial data and expert opinion. Patients were assumed to accrue costs for 12 months until estimated treatment failure. Monthly treatment costs reflect approved EU dosing and list prices; cost of ponatinib was assumed equivalent to the US. RESULTS: We estimated 184,280, and 360 ponatinib-eligible patients in 2, Fagnani F., Gourmen J., Swarzenkost K., Laflamme A., INSERM, Villejuif, France, 2, Cemeka Evol, Bourg La Reine, France, 3, TETHUCAN SAS, Ixelles Brussels, Belgium, 4, Aubertin G., Université Libre de Bruxelles, Brussels, Belgium, 5, Burge P., University College London, London, UK.