of life for men (DLQI mean score of 4.89) compared to women. This score reflects quality of life impairment similar to patients suffering from acne or solar keratosis.

LIVING WITH A DERMATOSIS: A NATIONAL SURVEY OF DEPRESSIVE SYMPTOMATOLOGY IN BELGIUM

Lambert J1, De la Brassine M1, Myon E2, Weckx H2, Monnier F1, Martin N2, Taieb C2
1Royal Belgium Society of Dermatology, Brussels, Belgium; 2Health Economics & Quality of Life Dept, Boulogne-Billancourt, France;
2AVENE Dermatological Laboratories, Brussels, Belgium

OBJECTIVES: To assess the consequences of dermatological diseases on the quality of life of the patients and to perform an evaluation of depressive symptomatology among them. METHODS: Every Belgian Dermatologist received a sample of 30 questionnaires including the DLQI, the SF-12 and the CES-D. During the “National Week of Dermatology”, each participating dermatologist distributed the questionnaire to their first 30 patients coming to their consulting room and they made a register of all the dermatological diseases of their patients. The CES-D scale allows to perform epidemiological studies of depressive symptomatology in the general population. A score >17 indicates a possible depressive symptomatology, a score >23 indicates a probable depressive symptomatology. RESULTS: In total, 105 out of the 650 Belgian dermatologists completed the register. A total of 896 questionnaires were by 513 Flemish responders (57%) and 383 Walloon responders (43%). The male/female ratio was 37%/63% and the mean age was 46.76 years. The disease allocation was: Psoriasis 15%, Atopic Dermatitis & Contact Eczema 11%, Acne 11%, Warts 9%, Dry skin 8%, Others 46%. Possible depressive symptomatology was observed in 36% of the population (Flemish patients: 32%; Wallon patients: 44%). Concerning probable depressive symptomatology, 20% of our population (Flemish patients: 17%; Wallon patients: 26%, p < 0.01). CONCLUSIONS: Although females generally reported greater risk of high depressive symptoms, this is still a concern for males. In the Kield study assessing depressive symptoms in older men and women (age 65 to 75), 23.1% of women and 12.8% of men reported high depressive symptoms (CES-D score > or = 16). When we compare those results with the ones obtained in our current study, it confirms that dermatological diseases result in psychological changes that seriously affect patients’ lives.

COST-EFFECTIVENESS OF TREATMENT FOR MODERATE-TO-SEVERE PSORIASIS

Hankin CS1, Feldman SR2, Pearce D1
1BioMedEcon, San Jose, CA, USA; 2Wake Forest University School of Medicine, Winston-Salem, NC, USA

OBJECTIVES: There is a wide range of treatments for moderate-to-severe psoriasis, including oral systemics, biologics, and phototherapies; we evaluated their cost-effectiveness (in US dollars). METHODS: We conducted a systematic review of published, clinical studies from 1978 to 2004 describing outcomes for moderate-to-severe psoriasis in terms of the Psoriasis Area and Severity Index (PASI). We determined the weighted mean PASI improvement across studies for acitretin, alefacept, cyclosporine, efalizumab, etanercept, infliximab, methotrexate, narrowband ultraviolet B (NBUVB), broadband ultraviolet B (BBUVB), psoralen with ultraviolet A (PUVA), BBUVB combined with acitretin, and PUVA combined with acitretin. The model perspective is of the US health systems payer, and includes 1-year medication (US Average Wholesale Price) and related treatment (Medicare reimbursement) costs. Cost-effectiveness (defined as the cost per 1% PASI improvement) was calculated as: Total Treatment Costs [medications or phototherapy + administration of treatment (e.g., IV infusion) + monitoring (e.g., diagnostic procedures) + risk-adjusted costs of adverse events] divided by mean PASI improvement. RESULTS: We found wide variation in annual drug costs, ranging from $1388 (methotrexate) to $24,894 (infliximab). Annual costs of treatment administration ranged from $0 (oral systemics) to $1438 (infliximab). Annual costs of monitoring ranged from $0 (etanercept) to $2,306 (alefacept). Risk-adjusted costs of adverse events ranged from $0 to $98. PASI improvement varied from 37% (alefacept 15mg IV) to 85% (PUVA with acitretin). The annual cost per 1% PASI improvement was: $37 for methotrexate, $46 PUVA, $91 cyclosporine, $120 NBUVB, $166 PUVA with acitretin, $167 BBUVB with acitretin, $197 acitretin, $265 BBUVB, $325 infliximab, $337 efalizumab, $390 etanercept, and $472 alefacept IM.

COMPARING TREATMENT COSTS ASSOCIATED WITH SCREENING FOR GLAUCOMA VS NOT SCREENING: EVALUATING THE ECONOMIC IMPACT OF THE NEW HEDIS MEASURE

Goldberg LD1, Walt JG2, Lee J1
1Goldberg, MD and Associates, Battle Ground, WA, USA; 2Allergan Inc, Irvine, CA, USA

OBJECTIVES: To compare the expected U.S. payer costs associated with screening and early treatment of glaucoma patients vs. non-screening of this asymptomatic progressive disease. METHODS: A 14-year economic model was developed to evaluate costs associated with biennial screening and early treatment and compare it to not-screening, resulting in patients presenting at slightly more advanced mild stages of this progressive disease. Total costs included screening costs, drug costs, office visits, and surgical treatments associated with glaucoma. Treatment costs and disease progression rates were taken from recently published literature. Non-screened patients were assigned zero costs for seven years followed by treatment costs for mild disease for seven years. Screened patients were assigned every-other-year screening cost for 14 years, with a proportion of screened patients at risk assigned early/mild glaucoma treatment costs. Patient epidemiology rates were based on non-Medicare patients aged 40–64 years old. Multi-factor sensitivity analyses were conducted. RESULTS: Total expected costs to “screen and treat” over 14 years are estimated to be $8,910 per patient or $636 per patient per year compared to “not-screen” for 7 years followed by 7 years of treatment costs of $10,458 or $1,494 per patient per treated year. In sensitivity analyses, the difference in total expected plan costs varies around cost-neutral. CONCLUSIONS: Total expected payer costs for screening for glaucoma will be cost neutral over the early years of the disease and will be cost saving during the more expensive progressive years. Cost considerations must be balanced with patient concerns of advancing to blindness and patient/plan benefit with this new HEDIS measure.