proportion was significantly higher in males than females (25.7% vs. 20.0%, p < 0.001). Overall mean age was 45.84 (IP 46.64; OP 45.62, p < 0.001). Proportion of IP among all LCs was significantly higher among older people (18–34y: 20.4%; 35–44y: 19.9%; 45–54y: 20.2%; 55–65y: 24.7%, p < 0.001). IP proportions by diagnosis were: calculi of the gall bladder and/or bile duct, 31.8%; other gall bladder disorders (including cholecystitis), 13.9%; diseases of the pancreas, 87.6%; and all other diagnoses, 41.3% (p < 0.001). Mean net cost for LC hospital admission was $9168 (95% CI: $8913–$9424) and average LOS was 3.6 days (95% CI: 3.4–3.8). Net OP procedure cost for LC was $3158 (95% CI: $3123–$3194).

CONCLUSIONS: Nearly 80% of LCs in the US managed care population were ambulatory-based. Patients undergoing IP LC were significantly different from patients undergoing OP LC in age, gender, and primary diagnosis. Cost of hospital-based LC was almost three times higher than cost of ambulatory-based LC.

Cost-minimization analysis of a pharmacist-directed, pantoprazole intravenous to oral dosage form conversion program

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OBJECTIVE: Several medications are equally efficacious regardless of dosage form. This study conducted a cost-minimization analysis from an institutional perspective of a pharmacist-directed intravenous to oral conversion program for pantoprazole, a proton pump inhibitor (PPI). Empirical evidence supports equivalence of IV and tablet forms of pantoprazole in inhibiting gastric acid secretion. METHODS: Patients on IV pantoprazole in select units at a tertiary care teaching hospital between March 15, 2002 and April 12, 2002 were included in the intervention group. Following a protocol approved by the Pharmacy & Therapeutics Committee, a pharmacist evaluated patients to determine eligibility for conversion to administration by mouth or nasogastric tube. The pharmacist recorded times required to identify and switch patients. Average times required for preparation, dispensing, and administration of dosage forms were determined via employee interview. Medication acquisition and labor costs were obtained from the hospital financial department. Proportion of days therapy with each dosage form for the intervention group and historical control group, which otherwise met identical inclusion criteria, were determined from the pharmacy database. RESULTS: A significant difference in proportion of days therapy with PPI dosage forms existed between control (N = 182) and intervention (N = 150) groups (C2 = 276.39, df = 2, p < 0.05). The intervention increased total proportion of days therapy with pantoprazole tablets and PPI suspensions by 6.9% and 22.0%, respectively. Days therapy with IV pantoprazole were decreased by 28.8% (from 61.2% to 32.4%). Applying costs for medications, supplies, and labor, the conversion program saves $13.45/patient started on IV pantoprazole. Projecting cost saving to 1 year with 1887 patients/year, the conversion program could save $25,380.15 in the hospital budget. CONCLUSION: A pharmacist-directed intravenous to oral dosage form conversion program can result in institutional cost savings. However, cost savings are dependent on success in converting patients. Cost savings would be increased to $18.50/patient on IV pantoprazole by shifting an additional 6.9% of PPI therapy days from IV pantoprazole to pantoprazole tablets.

GASTROINTESTINAL DISEASES/DISORDERS—Quality of Life/Preference Based Outcomes

DIFFERENCES BETWEEN ELDERLY AND YOUNGER ADULTS IN THE EPIDEMIOLOGY AND TREATMENT OF SYMPTOMATIC GERD AND NOCTURNAL GERD

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OBJECTIVE: To compare the epidemiology and treatment of GERD and nocturnal GERD in a U.S. national sample of elderly (65+ years of age) and younger adults (<65 years of age). METHODS: A national random-sample phone survey of 9035 adults identified 171 elderly and 1090 younger adults with symptomatic GERD, and 42 elderly and 329 younger adults with nocturnal GERD. Symptomatic GERD cases reported heartburn or regurgitation 1+ time/week in past three months. Nocturnal GERD was defined as symptomatic GERD with 1+ nocturnal symptom 1+ time/week. Severe was defined as 2+ episodes/week. The interview included questions on symptom frequency, concomitant motility-related symptoms, and treatment for GERD symptoms. Chi-square tested for statistical significance between elderly and younger adults. RESULTS: Prevalence of symptomatic GERD (9.9% vs. 14.9%; p < 0.0001) and nocturnal GERD (2.4% vs. 4.5%; p < 0.0001) was lower and less severe (74% vs. 87%; p < 0.05) in elderly than younger adults. Most bothersome symptoms were regurgitation in elderly, and heartburn in younger adults. Among GERD cases, motility-related symptoms (e.g., post-prandial fullness, early satiety) were less prevalent or less frequent in the elderly than younger adults. Among nocturnal GERD cases, prevalence of motility-related symptoms was not different between elderly and younger adults, but the elderly reported less severe post-prandial fullness (p < 0.05) and a lower frequency of nausea (p < 0.001) than younger adults. Prescription medication use for GERD-related symptoms was reported by 24% of nocturnal GERD cases and did not differ by age. However, elderly