end of 2007 and linked with the National mortality database. Kaplan-Meier method was used to yield the estimated survival function of both groups. Constant excess hazard model was used to project the long-term survival of these patients by utilizing linear extrapolation. Life expectancy was estimated while EYLL was calculated by subtracting the age at death of patients from those of their age- and gender-matched referents. HD patients were then matched with PD patients on age, gender, and diabetic status. Life expectancy, EYLL and survival for the two groups were re-compared. Cox Model was applied to determine the risks for mortality. RESULTS: A total of 301 HD and 422 PD patients were included. Before matching, HD patients were older than PD patients (62.4 ± 13.7 versus 53.1 ± 16.7 years, p = 0.0001), and more HD patients had diabetes mellitus (DM) (HD versus PD, 29.2% versus 20.6%, p = 0.0072). Life expectancy and EYLL of HD patients were 8.8 and 11.5 years, compared with those of PD patients (19.9 and 7.4 years). After matching, 236 pairs of HD and PD patients were selected. Life expectancy (p = 0.790) and EYLL (p = 0.793) of both groups were similar on re-analysis. Age (adjusted hazard ratio, AHR 1.07, 95% CI 1.05–1.09) and DM (AHR 3.81, 95% CI 2.28–6.36) were independent predictors of mortality. For diabetic patients, survival was better if the patients were treated with HD (AHR 0.24, 95% CI 0.11–0.53). CONCLUSIONS: After matching, life expectancy and EYLL between HD and PD patients were similar, but survival was better for diabetic patients if they were treated with HD.

**PUK6**

**ASSESSMENT OF CARDIOVASCULAR (CV) COMORBIDITY IN PATIENTS WITH OVERACTIVE BLADDER (OAB) DISORDER IN A REAL-WORLD SETTING**

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**OBJECTIVES:** To determine the proportion of OAB patients potentially at risk for adverse events based on CV comorbid conditions and CV medications as measured during the six months prior to OAB diagnosis/treatment by biologic measures, CV diagnoses, and CV concomitant drug use among treated and untreated OAB patients. METHODS: The GE Centricity EMR database was utilized to identify patients with a diagnosis of OAB using ICD-9 codes and prescription claims between January 1, 1996 to March 30, 2007 for an OAB antimuscarinic agent. The treated OAB patients with 13 months of continuous eligiblility pre- and post-index date formed the OAB cohort. Based on the presence of at least one CV medication claim for an OAB antimuscarinic agent, the OAB cohort was stratified as treated or untreated. A random sample of age and gender matched patients formed a comprehensive non-OAB control cohort; they had no diagnosis of OAB, urinary bladder dysfunction, or pharmacy claim for an OAB antimuscarinic agent. RESULTS: OAB patients (N: 41,440; 83.6% women; median age 65 years), when compared to non-OAB patients (N: 41,442; 81.2% women; median age 64 years), were more likely to have CV comorbidity (57.6% vs. 44.6%; p < 0.001), a high heart rate (280 beats / minute) (31.4% vs. 19.9%; p < 0.001), higher Framingham risk (9.9% vs. 9.6%; p < 0.003) as well as use of CV medications (37.1% vs. 38.8%; p < 0.001). In treated vs. untreated OAB patients, CV comorbidities (58.8% vs. 53.7%; p < 0.001), proportion with a high heart rate (32.3% vs. 27.6%; p < 0.001) and Framingham risk (10.2% vs. 9.8%; p < 0.003) and use of CV medications (60.7% vs. 42.4%; p < 0.001) also differed. CONCLUSIONS: CV comorbidities were more prevalent in OAB patients that were treated as compared to untreated among the OAB patients, CV comorbidity and poor exposure to CV medications was more prevalent in those who received antimuscarinic treatment than in patient who did not receive treatment.

**PUK7**

**HOSPITAL DISCHARGE COST AND LENGTH OF STAY OF PERITONEAL DIALYSIS AND HEMODIALYSIS**

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**OBJECTIVES:** This study evaluates the difference in total hospital charges and length of stay (LOS) between peritoneal dialysis (PD) and hemodialysis (HD) patients. METHODS: Hospital inpatient data was analyzed from the Healthcare Cost and Utilization Project’s 2006 National Inpatient Sample. Patients were identified as HD or PD by a procedure code of 39.95 or 54.98, respectively, and a diagnosis code for end-stage renal disease (585.6). Exclusion criteria include having a procedure code for both PD and HD, a diagnosis code for acute renal failure (584.x), or under age 18. Differences in LOS and total charges were analyzed using univariate and multivariate analysis adjusted for age, gender, and comorbidities. Subgroup analyses were done by payer type. RESULTS: 350,409 HD and 22,031 PD discharges met inclusion and exclusion criteria. PD patients were younger, more female, and had less comorbidity. The mean total charge for a PD discharge was $15,846 compared to $41,336 for HD (p < 0.0001). The mean LOS was 6.7 days for PD and 7.25 days for HD (p < 0.0001). After adjusting for covariates, HD total charges were 13.9% higher than PD (p < 0.0001) and LOS was 6.7% longer (p = 0.0006). For Medicare patients, total charges were 10.0% higher in HD patients (p < 0.0001) and LOS was not different between HD and PD. For patients with private insurance, mean total charges were 21.7% higher in HD patients (p < 0.0001) and LOS was 9.2% greater (p < 0.01). The charge difference, HD minus PD, between private and Medicare patients was significantly higher in the former. CONCLUSIONS: Adjusted mean total charges and LOS were significantly higher in patients receiving HD compared to PD. LOS was significantly longer in privately insured HD patients but not in Medicare HD patients. The charge difference between HD and PD was significantly higher in privately insured compared to Medicare patients.