The study was naturalistic and thus the aim was to investigate the impact of remission in clinical practice, without any pre-specified protocol for the GPs to follow. Cox regression analysis was employed to analyse which factors influence the time to achieve remission. RESULTS: Fifty-two percent of the patients achieved remission during the study period. During a period of six months, remitting patients have on average three outpatient care visits less than non-remitting patients (p = 0.0001), and substantially less sick-leave days: 22 days per year (p = 0.0106). Remitting patients have a significantly lower total cost ($3,400 during 6 months) compared with non-remitting patients (p = 0.0001). Moreover, the average EQ-5D index score was 0.24 higher in remitting patients (p = 0.0001). Severely depressed patients have 60% lower chance of achieving remission quickly than milder cases of depression (p = 0.002). CONCLUSIONS: Remission has a substantial health economic impact and we have shown both statistically significant reductions in cost as well as improved quality-of-life. Our results argue for the importance of aiming for full remission in the antidepressive treatment of depression, and hence indicating that antidepressants that rapidly lead to full remission may be cost-effective.

MEASUREMENT OF UTILITY LOSSES IN DEPRESSION
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OBJECTIVE: To identify utility weights for use in cost-utility analyses of antidepressants. METHODS: Systematic search of MEDLINE using search terms for depression and utility/acceptance weights. Utility weights by depression severity and changes in utility by response to treatment were abstracted. Methods used to derive utilities were cross-tabulated with the values obtained. RESULTS: Six published studies were reviewed. Three studies obtained utility weights using the standard gamble (SG) method, one study used the SG and time trade-off (TTO) methods, one study used the EQ5D TTO weights, and one study used the quality of well being (QWB) scale weights. One of the SG studies compared utility for those with and without depression over a 10-year time horizon (0.942 (standard deviation (SD) 0.159) versus 0.963 (SD 0.144)). The other three SG studies compared utility for different depression severity and, depending on the whether the SG lottery was presented for temporary or lifetime health states, estimated utilities for severe depression were between 0.09 (SD 0.02) and 0.813 (SD 0.209) and for mild depression were between 0.59 (SD 0.02) and 0.871 (SD 0.184). Three of the six reviewed studies compared the gain in utility for those who responded to treatment to those who did not. The gain in utility for responders compared to non-responders in these studies was: 0.053 at 1 year using the SG lifetime method; 0.180 at 4 months using the QWB weights; and 0.220 at 2 months using the EQ5D TTO weights. CONCLUSIONS: Published estimates of utility weights for people with depression and of the gains in utility in people recovering from depression vary considerably depending on the method of assessment. We recommend that utility gains for antidepressant treatments be estimated using SG for temporary health states along with sensitivity analyses using alternative methods of utility assessment.
HOSPITAL LENGTH OF STAY ASSOCIATED WITH ANTICONVULSANT UTILIZATION BY PATIENTS WITH SEIZURE DISORDERS IN THE U.S.
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OBJECTIVES: Comparing length of stay by anticonvulsant therapy may be the first step to identifying adverse events associated with treatment as well as treatment effectiveness. This study attempts to determine the association between the hospital length of stay and the use of anticonvulsants by inpatients with seizure disorders. METHODS: A cohort of 126,362 patients admitted to U.S. hospitals from July 1, 2004 to June 30, 2005 with a diagnosis of seizure or epilepsy was constructed using data from Premier’s Perspective Comparative Database. Anticonvulsant use was tracked throughout each patient’s hospital stay and patients were categorized by drug into carbamazepine, clonazepam, divalproex, fosphenytoin, gabapentin, lamotrigine, magnesium, oxcarbazepine, phenytoin, topiramate, valproic acid, levetiracetam, and other anticonvulsants groups. Descriptive statistics including demographic characteristics and drug utilization were reported for the sample. Mixed regression models were used to control for selection bias due to patient clustering within hospitals. The model observed the impact of anticonvulsant monotherapy by drug on length of stay. RESULTS: Mean length of stay for non-users were 5.63 (SD = 9.02) and drug users ranged between topiramate users with 5.42 (SD = 6.20) and magnesium users with 12.99 (SD = 18.27). Clonazepam (t = 5.41, p < 0.0001), divalproex (t = 5.09, p < 0.0001), gabapentin (t = 7.25, p < 0.0001), magnesium (t = 40.76, p < 0.0001) and phenytoin (t = 7.58, p < 0.0001) were significantly associated with length of stay while controlling for race, gender, age, severity of illness and admission status. CONCLUSIONS: Further analysis should investigate patterns of events associated with increased length of stay in patients taking clonazepam, divalproex, gabapentin, magnesium, and phenytoin for identification of potential adverse events.