PHYSICIANS’ STATED PREFERENCES OVER BENEFITS AND RISKS ASSOCIATED WITH NSAID USE IN PATIENTS WITH OSTEOARTHRITIS IN UNITED KINGDOM

Objectives: To estimate physicians’ preferences over benefits and risks of NSAIDs. METHODS: Physicians were categorized as GPs or specialists. The survey was designed with 64 attributes, each rated on a 0–10 (low–high) importance scale. RESULTS: Benefits were prioritized over risks by 3.45 (95% CI: 3.15–3.75) and hypertension (3.25; 95%CI:3.2–3.4). There were no statistically significant differences in preferences between GPs and specialists. CONCLUSIONS: Ambulatory pain and the incremental risk of heart attack were the most important NSAID-related attributes that influence physicians’ treatment choices. Preferences did not vary between GPs and specialists. The findings confirm that benefit-risk tradeoffs are important aspects in treatment selection for OA management.

ECONOMY OF NSAIDS IN THE MANAGEMENT OF OSTEOARTHRITIS: SODIUM CHONDROITIN SULFATE VS. CONTROL GROUP

Objectives: Describe the potential economy of NSAIDs in a population of patients with osteoarthritis newly-treat with a sodium chondroitin sulphate (SCS) versus a control group. METHODS: The Disease Analyzer database (IMS), which collects medical data from 1240 representative French GPs was used. The control group consists of patients diagnosed with knee or hip osteoarthritis during the observation period but not treated with symptomatic slow acting drugs for osteoarthritis throughout the study period, no during the year before the study or the following year. RESULTS: 24% of patients were included, 472 per group. The characteristics of both groups in terms of age, sex, time since diagnosis and type of osteoarthritis are strictly the same. 80% of patients included suffered from osteoarthritis of the knee, a total of 33.4% of patients included in study received one or more prescriptions for NSAIDs in the year prior to their inclusion. Half of the patients in the SCS group received at least one NSAID prescription during initiation or during the 1-year follow-up period. This % is significantly higher in the control group (64%); P < 0.01. 18% of patients in the SCS group stopped their treatment with NSAIDs at the initiation of SCS and did not resume it during the follow-up year, versus 11% in the control group. This difference is significant (p = 0.01). Patients in the SCS group require significantly fewer days of treatment with NSAIDs expressed in DDD than patients in the control group: on average 49 days of treatment versus 64 (p = 0.01). CONCLUSIONS: One of the public health goals set by health authorities—to reduce the incidence of iatrogenic complications (serious bleeding or gastrointestinal events) by 20% in osteoarthritis patients could be attained by a prescription of SCS. Indeed, this study highlights the fact that, in actual use, patients in the SCS group are significantly less likely to use NSAIDs (~22%).

MUSCULAR-SKELETAL DISORDERS – Conceptual Papers & Research on Methods

IMDIRECT TREATMENT COMPARISON TO COMPARE EFFICACY IN HEALTH ASSESSMENT QUESTIONNAIRE (HAQ) SCORE FOR BIOLOGIC AGENTS WITH METHOTREXATE IN PATIENTS WITH RHEUMATOID ARTHRITIS AND ACTIVE DISEASE DESPITE METHOTREXATE THERAPY

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1Bristol-Myers Squibb Pharmaceuticals Ltd, Uxbridge, Middlesex, UK; 2Mapi Values, Houston, The Netherlands; 3The Parker Institute; Mucosukleatityke Search Unit (PSU), Copenhagen, Denmark; 4Imperial College London, London, UK; 5Bristol-Myers Squibb, Braine-l’Alleud, Belgium. OBJECTIVES: To compare the efficacy in terms of HAQ score between abatacept and other biologic Disease Modifying Anti-Rheumatic Drugs (DMARDs) in patients with rheumatoid arthritis taking concomitant methotrexate (MTX) who have inadequate response to MTX (MTX-IR). METHODS: A systematic literature review identified controlled trials investigating the efficacy of abatacept (3 studies), etanercept (2), infliximab (3), adalimumab (2), certolizumab pegol (2) rituximab (2), and tocilizumab (3) in MTX-IR patients. The identified trials were comparable in design, included patients, and concomitant treatment (MTX). Mixed treatment comparison analyses were performed on HAQ change from baseline (CBB) at 24 and 52 weeks. Results were expressed as difference in HAQ CBB score between treatments and expected HAQ CBB and the 95% Credible Interval (CI) per treatment at 24 and 52 weeks. RESULTS: The analysis of HAQ CBB at 24 weeks showed that abatacept/MTX is more efficacious than MTX monotherapy (~0.30; 95%CI:~0.49–0.19) and shows small numeric differences versus other biologic/MTX (range: ~0.11±0.08). The expected mean HAQ CBB at 24 weeks for abatacept (~0.58) was superior to placebo (~0.28) and comparable to all the alternative treatments (adjusted mean between ~0.47 and ~0.66). The findings at 52 weeks are in line with those at 24-weeks, although no data was available for tocilizumab and golimumab. Scenario analyses confirmed the robustness of the findings. CONCLUSIONS: All biologic DMARDS in combination with MTX in the treatment of MTX-IR patients resulted in improvements from baseline. HAQ score compared to MTX monotherapy at 24–52 weeks. All biologic DMARDS in combination with MTX are expected to result in a comparable improvement in HAQ score.

INTERACTIVE ELECTRONIC INTERFACES (IEI): BRIDGING THE COMMUNICATION GAP BY TRANSLATING ECONOMIC ANALYSIS RESULTS TO DECISION-MAKERS EVERYDAY PRACTICE

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1MedInsight-Evidências, Rio de Janeiro, RJ, Brazil; 2Bayer Healthcare, São Paulo, SP, Brazil, 3MedInsight-Evidências, Campinas, Brazil. OBJECTIVES: Interfaces are interactive dashboards built with programs like Visual Basic for Applications, Crystal Xcelsius or Java. We aimed to demonstrate how IEI allow the translation of pharmacoeconomic studies’ results into understandable projections to decision makers. We present the economic evaluation of rivaroxaban in the prevention of thromboembolic events as a case study. METHODS: A model evaluating rivaroxaban in patients undergoing total knee and hip replacement was used. The model was adapted to different decision makers needs, namely Health Maintenance Organizations (HMO), hospitals, and physicians focused only on clinical outcomes. For each perspective, the following parameters could be customized: state taxes, time horizon of the analysis, choice of comparator (enoxaparin, dabigatran or both), duration of hospitalization, unit costs (drugs, treatment and diagnosis resources), eligible population and market share of comparators over the following five years. RESULTS: The IEI design for this case demonstrated that, under the perspectives of an HMO with 200,000 enrollees, the cost of rivaroxaban for a case where 80% of patients are treated with enoxaparin and 20% with dabigatran, and replacing every year 10% of enoxaparin cases with rivaroxaban would result in a budget impact of (~R$46,145) in 4 years for knee and hip replacement cases. The potential impact for cost offsets for the whole private system would be of (~R$3.8 million). Under the perspective of