only addressed absenteeism ± disability without regards to presenteeism; true productivity costs are likely even higher than reported. Cost assessment measures in clinical trials for fibromyalgia need to be determined.

DEVELOPMENT OF BENCHMARK METHODOLOGY TO IDENTIFY GOUT PATIENTS AND GOUT ATTACKS FROM A RETROSPECTIVE DATABASE ANALYSIS

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OBJECTIVE: To develop benchmark methodology for identifying gout patients and acute attacks, prevalence, patient characteristics, and rate of gout attacks from MCO data. METHODS: This retrospective study was in a 1.1 million southeastern US MCO. Patients had ≥2 visits with ICD-9 code for gout (274.xx) or ≥1 pharmacy script(s) for allopurinol, colchicine, probenecid, or sulfinpyrazone between January 1, 2000 and December 31, 2002 (intake period). Patients on allopurinol without an ICD-9 code for gout were excluded if they had neoplasm or nephrolithiasis. First gout claim/script within the intake period was the index date. Patients ≥18 years with continuous eligibility for one-year pre and post index date were included. Gout attack was defined as office or ER visit with medical claim for gout or joint pain (ICD-9 719.4x) and ≥1 of the following within seven days but not within six months prior: new pharmacy claim for NSAID, colchicine, corticosteroid, ACTH, intra-articular aspiration/injection, or microscopy of joint fluid. Statistical analysis was performed on continuous and categorical variables.

RESULTS: A study cohort of 5942 gout patients was identified with prevalence rate of 1.6%. In this database, gout patients were relatively older (mean age 57 ± 14 years), predominantly male (76%), suffered from substantial cardiovascular pre-index comorbidities (hypertension [40%], CHD [25%]), diabetes (18%), and renal impairment (5%). Nineteen percent (1121/5942) of patients had ≥1 gout attack. Among the gout attack subset, median rate of attacks per patient per year was 0.57 (range 0.24 to 6.9). CONCLUSION: Patients with gout were older, predominantly male, and had high rates of cardiovascular comorbidities. The prevalence rate identified is similar to other estimates in the literature. Further research is necessary to refine and validate our methodology since this work did not address self-managed gout attacks.

HEALTH CARE UTILIZATION AND DIRECT MEDICAL COSTS IN PATIENTS WITH RHEUMATOID ARTHRITIS IN AN DEVELOPING COUNTRY

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OBJECTIVES: To compare health care utilization and total direct medical cost in patients with Rheumatoid arthritis (RA) with those of the general population in a Hospital based Health Management Organization (HMO). METHODS: A total of 127 RA patients (all fulfilling ARA criteria 1982) (111 (87%) females, mean age 62.7 years, median disease duration: 6.7 (interquartile range: 4–11), 77% seropositive) with continuous affiliation with the HMO during year 2003 were included. All direct medical expenditures from the insurer’s point of view and health care utilization during year 2003 were considered and compared with mean values of the adult HMO population (n = 69,891), standardized by patient’s sex and age distribution. Data was obtained from charges to the HMO and considered as proxy to costs. Costs are expressed in 2003 American dollars.

RESULTS: RA had significantly more mean annual hospitalizations: 0.27 (SD0 .61) vs. 0.16 (SD 0.51), p = 0.025; mean annual medications purchased :34 (SD27) vs. 27.5 (SD 27) p = 0.01; mean annual medical visits 19 (SD11) vs. 14.5 (SD 14) p < 0.001, and outpatients procedures 48 (SD37) vs. 31 (SD 25); p < 0.001. RA patients also had significantly more mean total direct medical costs than general population ($752 vs. $537; p = 0.006). Components of direct medical costs were: medical visits: 13%, medications: 24%, hospitalizations: 38% and outpatient procedures: 25%. Only one patient was on biologic treatment. There were no differences in costs between seropositive and seronegative patients, males or females or in relation to disease duration.

CONCLUSIONS: RA patients used significantly more health care resources and were significantly more costly than the general population of same age and sex. In a developing country with scarce use of biologic therapy, direct medical costs are still mainly driven by hospitalizations.