1.67–1.80) and gabapentin (OR 1.56–1.69). Those seen by neurology were less likely to receive phenobarbital (OR .68–.75) and phenytoin (OR .73–.82), and more likely to receive gabapentin (OR 1.58–1.88) and carbamazepine (OR 1.28–1.35).
CONCLUSIONS: The elderly and those seen only in primary care were more likely to receive potentially problematic medications. Despite research findings, physicians may be reluctant to change efficient medications. The elderly tend to have more adverse effects from these medications, and while often subtle, they may result in injury and debilitation. Results highlight the need translate clinical research into best practices, and develop research programs that relate these practices to patient outcomes.

URINARY/KIDNEY DISEASES/DISORDERS—*Clinical Outcomes Presentations*

PUK1

A COMPARISON OF PD AND HD PATIENT SURVIVAL ALLOWING FOR SWITCHES FROM PD TO HD

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OBJECTIVES: Van Biessen (2000) concluded that: (1) intention to treat survival was not different between patients who started on HD and patients who started on PD; (2) the survival of patients who started on PD and switched to HD was better than the survival of patients who stayed on PD; (3) the survival of patients who started on PD and switched to HD was better than the survival of patients who started on HD and stayed on HD (J Am Soc Nephrol 11, 116–125, 2000). This study is a replication of the Van Biessen study, which was carried out in a Belgium hospital, to investigate whether these three conclusions apply to the Netherlands. Retrospective incidence data was used from the Dutch national ESRD registry (Renine).
METHODS: The Cox proportional hazards regression model was applied to analyse survival. Age, gender and a mortality risk factor were used as covariates. The mortality risk factor was derived from a classification of EDTA primary diagnosis in three groups according to low, medium or high mortality risk. Survival was studied over a 10-year period from 1990 to 2000.
RESULTS: The analyses revealed that: (1) the intention to treat survival of patients who started on HD did not differ from the survival of patients who started on PD. RR: 0.96 (95% CI: 0.93–1.00); (2) the survival of patients who started on PD and switched to HD was better than the survival of patients who stayed on PD. RR: 0.40 (95% CI: 0.37–0.43); (3) the survival of patients who started on PD and switched to HD was better than the survival of patients who started on HD and stayed on HD. RR: 0.49 (95% CI: 0.46–0.52).
CONCLUSION: All conclusions from the Van Biessen study were confirmed for the Netherlands.

PUK2

UTILIZATION PATTERNS ASSOCIATED WITH TOLTERODINE IMMEDIATE RELEASE VERSUS OXYBUTYNIN IN THE MANAGEMENT OF URINARY INCONTINENCE (UI)

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OBJECTIVES: Urinary incontinence (UI) is associated with adverse physical, psychological and economic outcomes effecting ~13 M Americans. UI is underreported and frequently untreated. First-line therapy includes agents decreasing incontinence frequency. This study characterizes utilization associated with tolterodine immediate release (TOL) versus oxybutynin (OXY).
METHODS: Drug markers associated with UI management in the Merck-Medco pharmacy claims database (N >= 65 M) were used to construct a continuously benefit-eligible, new therapy cohort from September 1, 1999–August 31, 2000. Utilization metrics were evaluated through August 31, 2001. All patients were followed for 12 months post-therapy initiation. Chronic disease scores were used to estimate patient chronic disease burden via drug markers during the 6 months preceding UI initiation. Propensity scoring via logistic regression was used to control for possible selection bias, and to create a matched cohort (N = 36,142) based on a minimum difference in propensity scores. Persistence was defined as any patient with drug supply on hand at least one day in the 12th month following the index prescription. Compliance measured the percentage of time between the first and last fills that the patient had drug supply "on hand".
RESULTS: Mean age was 62 years; 65% were female. Eight percent of the cohort had drug markers for diabetes (OHA or insulin) during the 6 months preceding UI therapy. Twelve-month persistence was higher for TOL patients than OXY patients (24.2% vs. 16.8%, $p < .0001$). TOL patients were more compliant than OXY patients (mean = 71.0% VS 64.3%, $p < .0001$). Compliance and persistence differences were slightly more pronounced in diabetics; TOL compliance mean was 75.9% vs. OXY 65.3% ($p < .0001$), while 30.8% of TOL diabetics were persistent, compared to 19.3% of OXY diabetics ($p < .0001$).
CONCLUSIONS: TOL had higher persistence and compliance rates than OXY. These improvements in compliance and persistence differences were slightly more pronounced in diabetics. This data suggests that differences exist between pharmaceutical agents used to manage UI.