identifying Veterans at risk for poor mental health may be working to provide health care benefit coverage but the persistence of symptoms, amongst those enrolled, may suggest a need for improved treatment or surveillance.

PMH71

HISTORY OF ANTIDEPRESSANT USE AMONG PRIMARY CARE DEPRESSED PATIENTS SWITCHING TREATMENTS IN THE UNITED KINGDOM

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OBJECTIVES: Major depressive disorder is characterised by the presence of one or more major depressive episodes. Up to one-third of patients do not adequately respond to first-line therapies. In case of treatment failure, the most common strategy is to switch to another antidepressant drug (AD). However, patients may have been exposed in prior episodes to one or more other ADs, which could impact the efficacy of subsequent treatments. This study describes historical AD use in depressed patients undergoing treatment switch. **METHODS:** This retrospective longitudinal cohort study used a database of medical records from general practitioners located throughout the UK (CPRD). Adult patients with a depression diagnosis undergoing an AD switch between 01/01/2012 and 30/06/2013 and with no diagnosis of schizophrenia or bipolar disorder were included. Historical AD use was assessed on all available prescriptions prior to switch and was grouped by treatment class (SSRI, SNRI, TCA and others). **RESULTS:** 11,611 patients were identified. Their mean age was 44.5 years (SD=16.18) and 66.7% were women. Prior to switch, patients used 2.65 different classes of ADs on average (SD=1.89); at least two different classes of ADs were prescribed for 64.8% of patients. Before the switch, SSRIs were the most common (1.65/patient) followed by TCAs (0.51/patient), other ADs (0.31/patient) and SNRIs (0.18/patient). Significant proportions of patients had previously been prescribed several AD classes: 34.1% of patients received at least one SSRI and one TCA, 24.0% at least one SNRI and one TCA, 15.0% at least one SSRI and one SNRI, and 13.7% at least one TCA and one other AD prior to AD switch. **CONCLUSIONS:** This analysis showed that for patients initiating an AD switch, historical use of ADs was very common, and that a substantial proportion of patients had already been prescribed several ADs, thereby reducing the treatment options for future switches.

PMH72

TREATMENT PATTERNS AND HEALTH CARE COSTS IN PATIENTS WITH DEPRESSION TREATED WITH ANTIDEPRESSANT ONLY OR COMBINED WITH BENZODIAZEPINE: RESULTS FROM A JAPANESE CLAIMS DATABASE ANALYSIS

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OBJECTIVES: To describe and compare treatment patterns and health care costs in patients with depression initiating treatment with antidepressant (AD) (in monotherapy or in combination) and patients initiating AD treatment combined with benzodiazepine (BZD) using claims database in Japan. **METHODS:** Using data from the Japan Medical Data Center (JMDC) database, a retrospective longitudinal cohort study was conducted, including adults aged 18-65 years with a first prescription of AD (index date) between January 2009 and September 2013, and diagnosed with major depression around index date. Time to treatment discontinuation (gap of 90 days without AD treatment) and total costs at 6 and 12 months were estimated for each group (AD vs. AD+BZD), and compared, with adjustment on potential confounders (gender, age, insurance status, index year and baseline costs) using Cox proportional-hazards regression and log-linear regression models. **RESULTS:** 7,723 patients were included (43.7% initiating treatment with AD+BZD and 56.3% initiating with AD). Mean age of the population was 36.5 years and 59.1% were males, with no significant differences found between the groups (p=0.14 and p=0.39 respectively). The total health care costs at 6 months were significantly higher in AD+BZD patients (¥176,946 vs. ¥151,992; p<0.0001). After adjustment, AD+BZD treatment was associated with higher costs at 6 months (+5.2%, IC95%: [+4.7 %; +5.8 %], p<0.0001) and at 12 months (+6.4%, IC95%: [+5.7%; +7.1%], p<0.0001). Time to discontinuation was longer for the AD+BZD group (HR=0.758, p<0.0001). **CONCLUSIONS:** A large proportion of patients with depression were treated with AD+BZD at initiation, a practice not recommended in Japanese guidelines. Patients treated with AD+BZD tend to have higher costs than patients treated with AD. The combination with BZD is associated with longer treatment duration and further analyses are recommended to determine if this is related to improved persistence or longer time to remission.

PMH73

LEVEL OF TESTING FOR POTENTIAL MEDICATION-RELATED CO-MORBIDITIES FOR PATIENTS TAKING ANTIPSYCHOTICS

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OBJECTIVES: Patients taking antipsychotics are at higher risk for other co-morbid diseases, including metabolic-related conditions. The objective of this study was to determine the level of testing for potential medication-related co-morbidities, looking at rates of Hemoglobin A1c (HbA1c) and fasting blood sugar (FBS) tests for diabetes as well as lipid panel tests for hyperlipidemia. **METHODS:** Using Texas Medicaid claims for 2012, a total of 135,757 patients filled at least one prescription for an antipsychotic medication. Claims data on lab testing were extracted for these patients. **RESULTS:** Overall, 36.0% of patients taking antipsychotics received a lipid panel test, 18.7% received an HbA1c test, and only 6.5% received a FBS test. Nine percent and 95.8% of patients had claims for first- and second-generation antipsychotics (FGAs and SGAs), respectively [some patients had both prescribed]. A total of 53.5% were male and 46.5% were female. A larger proportion of patients taking FGAs had HbA1c, FBS, and lipid panel tests compared to patients taking SGAs: 28.9% vs. 18.4% (HbA1c); 8.1% vs. 6.4% (FBS); 49.8% vs. 35.6% (lipid panel). A larger proportion of females had HbA1c, FBS, and lipid panel tests compared to males: 23.4% vs. 14.8% (HbA1c); 7.6% vs. 5.6% (FBS); 40.7% vs. 32.3% (lipid panel). In addition, patients were divided into four age groups: < 13 years (children) [22.7%], 13-17 years (adolescents) [17.3%], 18-40 years [30.0%], and >40 years [30.0%]. The prevalence of HbA1c, FBS, and lipid panel testing significantly differed among the groups overall, and increased with increasing age, for both FGAs and SGAs. **CONCLUSIONS:** It is recommended that patients taking antipsychotics be tested regularly for glucose and lipid changes. Only about one-third of patients taking antipsychotic medications had a lipid panel test, and less than one-fifth had an HbA1c or FBS test during the 12 months of analysis.

PMH74

TREATMENT PATTERNS AND HEALTH CARE COSTS IN PATIENTS WITH SCHIZOPHRENIA INITIATING WITH FIRST- OR SECOND-GENERATION ANTIPSYCHOTIC: RESULTS FROM A JAPANESE CLAIMS DATABASE ANALYSIS

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OBJECTIVES: To describe and compare treatment patterns and health care costs in patients with schizophrenia initiating treatment with first-generation antipsychotic (s) (FGA) and patients initiating treatment with second-generation antipsychotic (s) (SGA) using claims database in Japan. **METHODS:** Using data from the Japan Medical Data Center (JMDC) database, a retrospective longitudinal cohort study was conducted, including adults aged 18-65 years with a first prescription of antipsychotic (index date) between January 2009 and September 2013, and diagnosed with schizophrenia around index date. Time to treatment discontinuation (gap of 90 days without antipsychotic treatment), time to switch, time to psychiatric hospitalisation and total costs at 6 and 12 months were estimated for each group (FGA vs. SGA), and compared, with adjustment on potential confounders (gender, age, insurance status, index year and baseline costs) using Cox proportional-hazards regression and log-linear regression models. **RESULTS:** 2,615 patients were included (14% initiating treatment with FGA and 86% initiating with SGA). 55.0% were female, with no significant difference between the groups (p=0.22). FGA patients were older than SGA patients (40.1 years vs. 34.1, p<0.0001). The total health care costs at 6 months were significantly higher in FGA patients (¥1,489,680 vs. ¥324,595; p<0.0001). After adjustment, FGA treatment was associated with higher costs at 6 months (+121%, IC95%: [+93%; +152%], p<0.0001), and at 12 months (+87%, IC95%: [+60%; +119%], p<0.0001). Time to discontinuation as well as time to hospitalisation were shorter for the FGA group but did not reach significance (HR=1.146, p=0.09; HR=1.406, p=0.07 respectively). The probability of switching was higher in the FGA group (HR: 5.281, p<0.0001). **CONCLUSIONS:** A large proportion of patients with schizophrenia were treated with SGA at initiation, consistently with previous studies conducted in Japan. Patients treated with SGA tend to have longer treatment duration and lower costs than patients treated with FGA.

URINARY/KIDNEY DISORDERS – Clinical Outcomes Studies

PUK1

COMPARATIVE EFFICACY AND TOLERABILITY OF SOLIFENACIN 5MG VERSUS ORAL ANTIMUSCARINIC AGENTS IN OVERACTIVE BLADDER (OAB): A SYSTEMATIC LITERATURE REVIEW (SLR) AND MIXED TREATMENT COMPARISON (MTC)

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OBJECTIVES: To compare the efficacy and tolerability of oral first-line antimuscarinic agents recommended for the treatment of OAB. **METHODS:** Literature searches were undertaken to identify published randomised controlled trials (2000–2012), which reported efficacy and/or tolerability in adults receiving pharmacological treatment for OAB. Bayesian MTC methodology was used to assess changes from baseline in micturition frequency per 24h, urgency, incontinence, and urge incontinence (UI). Safety outcomes included dry mouth, constipation, and blurred vision. **RESULTS:** Forty-one eligible trials involving 25,118 patients were included in the MTC. Solifenacin 5mg was significantly more effective than darifenacin 7.5mg based on incontinence (mean difference [MD]=0.531/day), fesoterodine 4mg based on micturition (MD=0.374/day), and tolterodine 4mg based on micturition (MD=0.387/day), urgency (MD=0.434/day), incontinence (MD=0.309/day), and UI (MD=0.416/day). However, the starting dose of solifenacin 5mg was significantly less effective than solifenacin 10mg according to micturition (MD=–0.343/day), and urgency (MD=–0.391/day). No other significant efficacy differences were reported. Solifenacin 5mg had a significantly lower risk of dry mouth compared to oxybutynin (intermediate-release) IR 9mg (odds ratio [OR]=2.732) or 10mg (OR=3.534), oxybutynin extended-release (ER) 10mg (OR=1.714), tolterodine IR 4mg (OR=1.763), and solifenacin 10mg (OR=2.470). Tolterodine ER 4mg (OR=0.481) or IR 4mg (OR=0.440), oxybutynin IR 9mg (OR=0.429) or ER 10mg (OR=0.440), and fesoterodine 4mg (OR=0.463) were associated with a significantly lower risk of constipation than solifenacin 5mg. Solifenacin 10mg was associated with a higher risk of constipation (OR=1.804) and blurred vision (OR=1.730) than solifenacin 5mg. **CONCLUSIONS:** This MTC suggests that the 5mg starting dose of solifenacin is more effective than the 4mg starting dose of tolterodine in reducing symptoms of OAB; solifenacin 5mg also has similar or better efficacy than the starting doses of other antimuscarinic agents across the spectrum of symptoms analysed. The lower risk of dry mouth with solifenacin 5mg may deliver improved treatment persistence.

PUK2

COMPARATIVE EFFECTIVENESS OF AUTOMATED VERSUS CONTINUOUS AMBULATORY PERITONEAL DIALYSIS ON PATIENTS WITH END-STAGE RENAL DISEASE IN TAIWAN

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