OBJECTIVES: Patients with unrecognized bipolar disorders (UBP) are often treated for depression prior to being correctly diagnosed, thus delaying appropriate drug therapy. This study compared hospital use, attempted suicides and one-year post-treatment costs of UBP patients relative to patients with major depressive disorders (MDD) and recognized bipolar (RBP) patients.

METHODS: Data from the California Medicaid program for the period October 1994 to January 1999 were used to identify 25,308 adult patients who initiated a new episode of antidepressant therapy. RBP patients received their initial diagnosis of bipolar disorders or used mood stabilizers on or before the initiation of antidepressant therapy. UBP patients initiated antidepressant therapy with an initial MDD diagnosis, then received a bipolar disorder diagnosis or initiated mood stabilizer therapy at a later date. Multivariate models were used to estimate the marginal risks and costs associated with UBP patients relative to RBP or MDD-only patients.

RESULTS: RBP and UBP patients represented 15.4% and 6.3% of all antidepressant users, respectively. UBP patients had higher rates of hospital use (12.5%) and attempted suicide (0.88%) than RBP patients (11.2% and 0.29%) or MDD patients (7.5% and 0.18%). Multivariate results indicated that UBP patients were three times more likely to use hospital services (p < 0.0001) and 3.2 times more likely to attempt suicide (p = 0.0004) than MDD patients. RBP patients were twice as likely to use hospital care (p < 0.0001) than MDD patients. UBP was associated with higher 1-year outpatient costs relative to RBP patients (+$200; p < 0.05), but was not associated with higher inpatient or total costs. RBP was associated with lower one-year outpatient costs ($109; p < 0.05) but higher inpatient costs ($634; p < 0.001) and total costs ($508; p < 0.01) relative to MDD patients. CONCLUSIONS: UBP is both common and costly. More effort is needed to provide early and correct diagnosis, and to effectively treat these patients.

PMH30
A COMPARISON OF MENTAL HEALTH RESOURCES USED BY PATIENTS WITH BIPOLAR DISORDER TREATED WITH RISPERIDONE, OLANZAPINE, OR QUETIAPINE
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OBJECTIVE: To compare the mental health resource use associated with risperidone, olanzapine, and quetiapine for treatment of bipolar disorder in a real-world setting.

METHODS: This was a retrospective, comparative study based on claims data compiled from several US health plans from 1999 to early 2002. Antipsychotic treatment episodes were constructed to more accurately identify mental health resources associated with risperidone, olanzapine, and quetiapine. Selection bias was reduced by focusing only on episodes involving antipsychotic monotherapy and for which the patient did not switch from a prior antipsychotic. The primary measure analyzed was non-antipsychotic mental health care charges per patient per month (PPM), defined as total mental health care charges excluding antipsychotic drug charges during treatment episodes with risperidone, olanzapine, or quetiapine. To control for differences in patient characteristics, regression models combining risperidone, olanzapine, and quetiapine treatment episodes were estimated to determine their effects on non-antipsychotic mental health resource use.

RESULTS: Regression estimates showed that quetiapine was associated with the lowest non-antipsychotic mental health care charges
PMM31

PATTERNS OF TREATMENT AMONG BIPOLAR DISORDER PATIENTS TREATED WITH ANTIDEPRESSANTS

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OBJECTIVE: This study compared treatment patterns for bipolar disorder (BP) patients (recognized and unrecognized) to those of major depression disorder (MDD) patients without a BP claim (non-BP) during the observational period. METHODS: An employer administrative claims database (covering several managed care health plans from 1998–2001) was used to identify 11,464 patients diagnosed with MDD and initially treated with antidepressants (AD). Of these, unrecognized BP (UBP) patients received their initial BP diagnosis and/or mood stabilizer (MS) prescription after AD initiation, while recognized BP (RBP) patients had these records on/before AD initiation. Induced BP patients were defined as those manifesting mania within six months after starting AD. RESULTS: BP patients accounted for 6.8% of the research sample (3.7% UBP and 3.1% RBP). Induced BP represented 6.6% of all BP patients. RBP patients had a slightly lower rate of induction (6.2%) than UBP patients (6.9%). The use of combination therapies varied in the non-BP, UBP, and RBP patients (11%, 32%, and 43%, respectively) (all pairwise p < 0.01). The use of MS was less frequent among UBP than RBP patients (14% and 34%, respectively) (p < 0.0001). CONCLUSIONS: A substantial number of AD-treated MDD patients could be classified as bipolar (either RBP or UBP), and were at risk for induction of mania. RBP and UBP patients initiated with more combination therapies, as compared to Non-BP patients. MS use increased when BP was recognized. More effort is needed to quickly diagnose and effectively treat BP patients.

PMM32

AN ECONOMIC COMPARISON OF ANTIPSYCHOTICS IN TREATMENT OF SCHIZOPHRENIA

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OBJECTIVES: A Markov model was developed to determine costs and outcomes of one year of antipsychotic treatment for patients with schizophrenia. METHODS: The model simulated a 4–armed, randomized, parallel, 12–month observational study of 2000 inpatients and 2000 outpatients initiating treatment on ziprasidone (Z), risperidone (R), olanzapine (O), or haloperidol (H). Equivalent efficacy between treatments was assumed; however, relapse rates on haloperidol were adjusted to be consistent with Czernasky et al. 2002. Weighted averages were used for published treatment-emergent adverse event rates for akathisia (Z = 7.9, R = 15.1, O = 7.8, H = 20.8), other extrapyrdidal symptoms (Z = 11.5, R = 9.0, O = 11.6, H = 26.7), weight gain (Z = 10.0, R = 14.8, O = 28.2, H = 11.0), and prolactin-related side effects (Z = 2.2, R = 11.2, O = 5.2, H = 3.0) to estimate tolerability, concomitant medication use, treatment changes, non-compliance, and relapse. Costs for inpatient care, sub-acute chronic care, and outpatient visits were based on published private and public medical claims databases. Medication costs were $170.63/month (Z = 120 mg/d), $242.61/month (R = 4.8 mg/d), $344.17 (O = 13.2 mg/d), and $6.72 (H = 15 mg/d) (RedBook 2002). Outcome measures included days in acute care, total direct medical costs, and incremental costs. RESULTS: Because of greater tolerability, estimated days in acute care were lowest for ziprasidone (42.4) when compared to olanzapine (42.8), risperidone (43.1), or haloperidol (53.6). Due to lower estimated days in acute care and lower maintenance treatment drug costs, estimated annual total healthcare costs for each drug cohort (n = 1000 patients per cohort) were lowest for those patients initiating treatment with ziprasidone vs. risperidone (+$787,000), olanzapine (+$964,000), or haloperidol (+$4,210,000). Sensitivity analyses to changes in model assumptions for adverse event, adherence, and relapse rates, and healthcare costs were robust to these conclusions. CONCLUSION: Ziprasidone has an adverse event profile distinct from those of other atypical antipsychotics and lower pharmaceutical acquisition costs, which potentially lead to improved outcomes and lower total direct costs.

PMM33

OLANZAPINE VERSUS RISPERIDONE IN THE TREATMENT OF SCHIZOPHRENIA: A MENTAL HEALTH COST COMPARISON IN A MANAGED CARE SETTING

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Because of equivalent efficacy, ziprasidone is considered by many to be a preferred atypical antipsychotic (AAP). It has an adverse event profile distinct from those of other atypical antipsychotics and lower pharmaceutical acquisition costs, which potentially lead to improved outcomes and lower total direct costs.