URINARY/KIDNEY DISORDERS – Clinical Outcomes Studies

PUIK INCIDENCE AND COST OF ADVERSE EVENTS (AES) IN PATIENTS WITH RENAL CELL CARCINOMA (RCC) TREATED WITH ANGIOGENESIS INHIBITORS (AIS)

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OBJECTIVES: The incidence of AES and the costs associated with the management of those AES have not been widely studied in patients with RCC receiving bevacizumab, sunitinib, sorafenib, or sunitinib. This study evaluates these outcomes using a large claims database.

METHODS: Patients with ≥ 2 RCC claims (ICD-9 189.0, 198.0) were identified in a large US commercial insurance claims database from 1/2002 through 12/2008. Patients were observed and analyzed during the time of their first AES treatment with bevacizumab, sorafenib, or sunitinib. AEs were defined as diagnoses that were treatment-emergent (i.e., diagnoses not present in the 6 months prior to initiation of AI treatment). The incidence rate (IR) and mean cost per visit for each AE were calculated in the outpatient, inpatient, and ER settings. Cost data represented actual payments made by insurers.

RESULTS: The incidence criteria identified 2481 bevacizumab, 375 sorafenib, and 472 sunitinib patients. The three most frequent AES experienced by patients in each treatment group were identified based on the overall IR. The specific IRs and costs per visit for these AES are: bevacizumab: outpatient = 20.3/1251, 16.1/1251, 11.9/1251; inpatient = 3.9/862, 22.2/1251, 1.5/1251. Mean costs for each AE were calculated in the outpatient, inpatient and ER settings. Cost data represented actual payments made by insurers.

CONCLUSIONS: The incidence of AES has not been widely studied in patients with RCC receiving bevacizumab, sorafenib, or sunitinib. This study demonstrates a high incidence of AES and their associated costs. Further research is warranted to evaluate strategies to prevent and manage these common AES.

PUIK VERSUS LIVER TRANSPLANTATION ALONE FOR END-STAGE LIVER DISEASE PATIENTS WITH IMPAIRED REINAL FUNCTION – A COMPARATIVE EFFECTIVENESS ANALYSIS

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OBJECTIVES: Chronic Kidney Disease (CKD) is a significant health care problem in the United States; iron deficiency anemia can greatly impact resource utilization. We compared patient and health characteristics and health care utilization of members with stage 3 CKD with anemia versus without anemia in a regional integrated health care system.

METHODS: Patients 18 and older were identified with a calculated GFR between 30 and 59 ml/min/1.73 m² (stage 3) using the MDRD equation or ICD-9 diagnosis code of 585.3 between July 1, 2004 and June 30, 2007. Patients were required to be continuously enrolled for 6 months pre- and 24 months post-index date. Anemia patients were identified with ICD-9 codes (280.0–280.9, 285.21, 285.29, or 285.9) or hemoglobin values (< 13 g/dl for females, < 14 g/dl for males) for each of the 6 months post-index date. Anemia patients were treated with either an erythropoietin stimulating agent (14.5%) or intravenous iron (85.5%). The incidence rate (IR) and mean cost per visit for each iron preparation was calculated in the outpatient, inpatient and ER settings. Cost data represented actual payments made by insurers.

RESULTS: Anemia patients were older than non-anemia patients (69.0 ± 12.9 vs. 62.5 ± 12.5 years, p < 0.0001) and female gender (OR = 2.37, p < 0.0001) also had higher risks of being incontinent. Advancements in lifestyle, management of comorbidities, use of atypical antipsychotics leads to increased UI risk. Since coping with UI continues to be a challenge in elderly population, newer antipsychotic medications should be developed to ensure safer treatments. In addition, closely monitoring the resident’s functional status and use of physical restraints would also help minimize incontinence in UI.

CONCLUSIONS: Higher prevalence of African-Americans and Mexican-Americans had a 51% increased risk of being incontinent (OR = 1.815, p < 0.0001). Concomitant use of other medications which may increase incontinence risk was not significantly associated with UI (p = 0.1016). Presence of comorbidities enhanced UI risk by 58.9% (OR = 1.589, p < 0.0001). Residents who were ADL dependent (OR = 1.224, p < 0.0001) or used bedrails (OR = 1.264, p < 0.0157), chairs (OR = 1.708, p < 0.0118) or trunical restraints (OR = 1.501, p < 0.0281) also had higher risks of being incontinent. Advanced age (OR = 1.022, p < 0.0001) and female gender (OR = 1.160, p = 0.0353) were also found to be other risk factors. Conclusions: The study results indicate that use of atypical antipsychotics leads to increased UI risk. Since coping with UI continues to be a challenge in elderly population, newer antipsychotic medications should be developed to ensure safer treatments. In addition, closely monitoring the resident's functional status and use of physical restraints would also help minimize incontinence in UI.