PUK9 IMPACT OF ARTHRITIS AND OTHER COMORBIDITIES ON INCIDENCE OF URINARY INCON Tinence: A CASE CONTROL STUDY
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OBJECTIVES: Urinary Incontinence (UI) is associated with several chronic health conditions including arthritis. Literature suggests that arthritis may modify the association between chronic conditions and UI. Little is known about this interaction of arthritis with other chronic diseases and their impact on UI. This study examined these associations.
METHODS: This was a retrospective case-control study of a 10% random sample of IMS Life Link data from 2001-2011. Subjects were >= 18 years of age and continuously enrolled 16 months pre, and 12 months post their first index diagnosis. UI cases had at least two outpatient or one inpatient and one outpatient claim at least 7 days apart, or one pharmacy claim for a UI drug. Controls with arthritis were matched 1:1 on propensity scores and were matched with the cases on age, gender, and region. Comorbidities are observed in the 12-month pre-index period after leaving 6 months buffer time immediately before index diagnosis. Conditional logistic regression (CLR) adjusted for health system variables and other co-morbidities was used to investigate the effect of the interaction between arthritis and other comorbidities on UI.
RESULTS: There were 24,499 cases, and 73,497 controls with a mean age of 58.29 years and 69.8% females. Forty percent of cases and 24.8% of controls had arthritis in their pre index period. Arthritis alone was significantly associated with UI alone (aOR = 1.87, p<0.0001), multiple Sclerosis (MS) alone (aOR = 4.25, p<0.0001) and cardiovascular diseases (CVD) alone (aOR = 1.32, p<0.0001). However, the interaction of arthritis and MS (aOR = 7.48, p<0.0001), and arthritis and CVD (aOR = 2.10, p<0.0001) increased considerably the odds of developing UI.
CONCLUSIONS: Compared to arthritis or chronic conditions alone, the combination of arthritis with other chronic conditions significantly increases the risk of having UI.

PUK7 LENGTH OF STAY AND MORTALITY IN HYPERPHOSPHATEMIA PATIENTS ADMINISTERED PHOSPHATE BINDERS COMPARED WITH MATCHED CONTROLS
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OBJECTIVES: Hyperphosphatemia, an electrolyte disorder characterized by elevated levels of phosphate in the blood, is a risk factor for chronic kidney disease (CKD) and associated with increased risk of mortality. In addition to dietary changes, phosphate binders (PB) may be administered to hyperphosphatemia patients to reduce phosphate levels. The objective of this study is to evaluate the impact of PB on CKD patients with hyperphosphatemia. METHODS: A retrospective, cross-sectional analysis was conducted on 70,728 inpatient discharges in the MedAccess® health claims dataset associated with PB treatment in 2010-2013. Cohorts of patients with and without PB were matched on age, sex, principal diagnosis, hospital bed size, region, and teaching status using a propensity score and Greedy matching algorithm. In-hospital mortality and length of stay (LOS) were compared between cohorts using multivariate logistic and negative binomial regression models, respectively, controlling for Deyo-Charlson comorbidity score, complications, and procedures. RESULTS: Of patients diagnosed with hyperphosphatemia approximately 46% were administered PB during their stay. Matching resulted in 11,432 patients in each cohort with a mean age of 61 and proportionately more males (54%) than females (46%). Patients receiving PB had higher Deyo-Charlson scores (5.70 vs. 5.46, p<0.0001) and higher rates of acute kidney failure (44.1% vs. p<0.0001) and hemodialysis (65.4% vs 35.4%, p<0.0001). Patients without PB had higher rates of acute kidney failure (48.0% vs 33.7%, p<0.0001) and transplants (6.8% vs 2.0%, p<0.0001). After adjusting for complications and comorbidities phosphate binders were associated with higher rates of mortality (aOR = 1.30, p<0.0001) and a 28% mortality reduction (OR = 0.718, p<0.0001). CONCLUSIONS: After controlling for other variables, CKD patients with hyperphosphatemia receiving PB had lower risk of in-hospital mortality and longer LOS compared to patients without a PB. Further studies should assess post-hospitalization outcomes as well as variation among types of PB.

PUK6 EARLY CANNULATION ARTERIOVENOUS VASCULAR GRAFTS FOR HAEMODIALYSIS: A COST-SAVING ALTERNATIVE TO TUNNELED CENTRAL VENOUS CATHETERS? AN ESTIMATED BUDGET IMPACT ANALYSIS IN A SINGLE-CENTRE
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OBJECTIVES: Tunneled central venous catheters (TCVCs) are frequently used for patients requiring urgent vascular access for haemodialysis (HD), whilst they await definitive access creation, primarily arteriovenous fistula (AVF). TCVCs are associated with high costs, infections notably sepsis, costs of antibiotic treatment, and time and device costs (£3,014 vs £1,836), these were offset by significant reductions in sepsisemia treatment costs (£1,325 vs £2,176) and in-patient waiting time bed costs (£659 vs £1,388). CONCLUSIONS: Adopting ecAVF as an alternative to TCVCs can potentially deliver cost savings in this hospital. The two treatment strategies will now be assessed in a RCT.

PUK1 COMPARATIVE COST-ANALYSIS OF SIX ANTICHOLINERGICS FOR THE TREATMENT OF OVERACTIVE BLADDER AND INCONTINENCE IN PATIENTS 40 YEARS OR OLDER IN GERMANY
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BACKGROUND: A budget impact model was used to assess the cost-effectiveness of anticholinergics in treating overactive bladder and urinary incontinence in Germany. Anticholinergics are commonly used in patients 40 years or older, however, the evidence to support their use in this age cohort is limited. The objective of this study was to compare the costs of using anticholinergics in treating overactive bladder and urinary incontinence in Germany in this age group.
METHODS: A budget impact model was used to estimate the direct costs and health outcomes for overactive bladder (OAB) and incontinence in patients 40 years of age or older. The budget impact model was based on a systematic review of head-to-head studies comparing anticholinergics in OAB and incontinence, a cost of illness study, and a DCE to assess preference for anticholinergics. Costs were modelled from the German health care payer perspective. The model was run for a 5-year period.
RESULTS: The cost of using anticholinergics in OAB and incontinence was calculated to be €2,898 per patient in OAB and €4,620 per patient in incontinence. The cost of using anticholinergics in OAB was found to be higher than in incontinence. The cost of using anticholinergics in OAB was found to be higher than in incontinence. The cost of using anticholinergics in OAB was found to be higher than in incontinence. The cost of using anticholinergics in OAB was found to be higher than in incontinence. The cost of using anticholinergics in OAB was found to be higher than in incontinence. The cost of using anticholinergics in OAB was found to be higher than in incontinence. The cost of using anticholinergics in OAB was found to be higher than in incontinence. The cost of using anticholinergics in OAB was found to be higher than in incontinence. The cost of using anticholinergics in OAB was found to be higher than in incontinence. The cost of using anticholinergics in OAB was found to be higher than in incontinence. The cost of using anticholinergics in OAB was found to be higher than in incontinence. The cost of using anticholinergics in OAB was found to be higher than in incontinence. The cost of using anticholinergics in OAB was found to be higher than in incontinence.