NSAID use did not have an increased risk (stage 2 OR 1.002, CI 0.952-1.068; stage 3 OR 0.936, CI 0.782-1.22) of rapid CKD progression compared to the no NSAID exposure group. Stage 2-3 CKD patients with high NSAID use trended toward, but did not achieve a statistically significant increased risk (stage 2 OR 1.185, CI 0.994-1.413; stage 3 OR 0.617, CI 0.844-1.927) of rapid CKD progression. CONCLUSIONS: NSAI use exposure over a two year period was not associated with an increased risk of renal dysfunction in our cohort of elderly patients with either stage 2 or 3 CKD.

PUK5
TREATMENT PATTERNS IN OVERACTIVE BLADDER: REAL-WORLD PATIENT POPULATION
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OBJECTIVES: To assess the prescribing, switching, and dose-adjustment patterns of overactive bladder (OAB) drugs in a real-world patient population. METHODS: A retrospective analysis of patients conducted using the Medstat MarketScan databases, which contain pharmacy claims for 28 million individuals across the US. Study patients received an OAB drug prescription between April 1, 2009 and April 30, 2010 with continuous enrollment 6 months before the index date. Demographics, diagnosis rate, prescription fill dates, patients who switched to or from a given OAB drug, and patients adjusting dosage were evaluated. RESULTS: A total of 214,721 patients had an OAB prescription (mean age 65 y, 76% women), 23% were diagnosed with OAB, 37% of patients resided in Southern, 35% in Northern Central, 18% in Western, and 9% in Northeastern regions of the United States. Many patients switched drug therapy during the study period, those receiving drugs with multiple dose options appeared to have often made dose adjustments rather than switching to a new agent (Table). For example, among patients prescribed solifenacin, 22% of switching patients increased the dose and 26% decreased the dose. The proportion of patients switching to another agent was higher among those receiving oxybutynin, tolterodine ER, and solifenacin than with fesoterodine, darifenacin, respectively. A total of 23% of patients switching to another agent was higher among those receiving oxybutynin, tolterodine ER, and solifenacin than with fesoterodine, darifenacin, and trospium. Among 32,782 (15%) patients who switched OAB medication at least once, the reasons for switching their initial prescription and either dose-adjusting or switching to a new agent was 139 (0–393) days and they filled a median (range) of 4 (2–41) prescriptions before dose-adjusting or switching. CONCLUSIONS: In this real-world population, patients take advantage of the ability to adjust between multiple doses of drugs for which a flexible-dose model. A systematic review was conducted of randomized (RCTs) and non-randomized trials (non-RCTs) published to April 2010 evaluating the effectiveness, safety or cost-effectiveness of LMWHs for use in hemodialysis (MDRD) equation and defined cases as those with an eGFR of less than 60mL/min/1.73m2. Presence of comorbid conditions was base on ICD-9 codes reported on the claims. Propensity score methods were used to match controls to cases. Data were analyzed using descriptive statistics and generalized linear models with a gamma distribution and log-link controlling for disease stage, health plan type, comorbidity conditions, and demographic characteristics. RESULTS: A total of 2,436 cases were identified with an eGFR of less than 60mL/min/1.73m2. We were able to match controls to 2,223 (91.3%) of the identified CKD cases using propensity scores. Unadjusted expenditures were $10,353 (sd 23,262) for CKD cases compared to $9,310 (sd 22,703) for matched controls. After adjusting for health plan type, comorbid characteristics, and comorbidity conditions, adjusted expenditures were significantly greater for patients with CKD compared to matched cases with a dependency on CKD expenditures. By stage ranged from 8% higher for stage 3 disease to 62% higher for patients with stage 5 CKD compared to matched controls. The key predictors of total treatment payments were disease stage, presence of diabetes, and rate of hospitalization. CONCLUSIONS: Payments for medical care attributable to CKD are significantly greater than medical care payments for those who do not have CKD and vary importantly by disease stage. Interventions that prevent or delay the progression of CKD have the potential to save considerable resources.