inhabitants). Setting 2 included all prescriptions provided by the Geneva University Hospitals to outpatients. RESULTS: Despite the commercialisation of citalopram generics as of October 2002, and despite the marketing of escitalopram as of March 2002, the total amount of citalopram prescribed remained constant from 2000 to 2007. The prescription of escitalopram increased from 2002 onwards. In January 2007, the volume of prescription in setting 1 was 12 Daily Defined Doses per 1,000 inhabitants (DDD/1000) for citalopram and 8 DDD/1000 for escitalopram. In setting 2, the DDD/1000 was around 1 for both citalopram and escitalopram. Around 76% of citalopram prescriptions were dispensed as generics in both settings. Considering all available dosages and conditioning forms in Switzerland, proprietary citalopram is 1 Euro per tablet more expensive than generic citalopram; escitalopram is 0.8 to 1 Euro per tablet more expensive than generic citalopram, depending on the size of the package. From April 2006 to March 2007, had only generic citalopram been prescribed instead of escitalopram, the total estimated savings would have been 0.95 million Euros. CONCLUSION: Prescription of generic citalopram instead of escitalopram could lead to major savings.

PMH19
COMORBIDITY AND COSTS IN GENERALIZED ANXIETY DISORDERS AND FIBROMYALGIA SYNDROME IN THE PRIMARY CARE SETTING (PCS): A COMPARISON OF TWO DISORDERS WITH HIGH DEMAND OF CARE
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OBJECTIVES: To evaluate the comorbidity and economical impact of two disorders of high demand of care in PCS: Generalized Anxiety Disorder (GAD) and Fibromyalgia Syndrome (FMS). METHODS: A retrospective multicenter population-based study was carried out, involving outpatient records of men and women above 20 years managed at seven PCSs during year 2006. Main outcomes measures were comorbidity as determined by Charlson index, health resources utilization (visits, diagnostic/therapeutic measures, referrals and drugs), days of work absenteeism (transient disability, TD), and corresponding costs. Four groups were established for comparison: population, FMS, GAD, both. The statistical analysis included a bivariate (ANOVA; Spearman-correlation) and analysis of covariance (ANCOVA). RESULTS: A total of 63,526 patients were included; aged 49.2 ± 17.8 years; 54.2% women. GAD group: 3,385 patients (5.3%); CI: 5.1–5.5%), age 55.3 ± 16.7 years; 70.5% women, FMS group: 904 patients, age 54.3 ± 9.8 years; 96.5% women. Both diagnoses: 177 patients, age 53.4 ± 11.1 years; 97.7% women. Depression was associated to the presence of FMS (42.4%) or both disorders (29.4%); p < 0.001. The Charlson index in GAD was 0.2 ± 0.5, versus 0.3 ± 0.6 in FMS; p < 0.001. Compared with the population group, the other three groups were older and had more comorbidities, p < 0.001. The mean adjusted monetary costs per patient per year were: € 535.92; € 909.02; € 817.69 and € 1140.88, respectively (p < 0.001). Mean transient disability days were, respectively: 55.5, 204.8, 123.9, and 256.3 days, p < 0.001. CONCLUSION: Patients with GAD are older and have greater comorbidities when associated with FMS. Adjusted costs are higher in FMS than in GAD, and increases (more than 2-fold) when the two disorders are combined, versus the general population.

PMH20
RESOURCE USE AND COSTS ASSOCIATED WITH CHANGES IN ANTIDEPRESSANT TREATMENT IN A MANAGED CARE POPULATION WITH MAJOR DEPRESSIVE DISORDER
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OBJECTIVES: To determine whether subjects with major depressive disorder (MDD) that switch/augment therapy have higher economic burden compared to those who stay on therapy. METHODS: Data were derived from a national-employment-based medical and pharmacy claims database. Index date was defined based on pre-specified antidepressant prescription claims between January 1, 2003–June 30, 2005. Subjects were treatment-naive 6-months prior to index-date, continuously enrolled, and had at least one outpatient-based medical claim for MDD (ICD-9 = 296.2x/296.3x) during study period. Study cohorts [switchers/augmenters/maintainers] were defined based on antidepressant prescription refill pattern 12-months post index therapy. Per-patient-per-year (PPPY) post-index resource use and costs were compared univariately (Wilcoxon tests) and multivariately (generalized-linear-model). All statistical comparisons were made in reference to the maintainer cohort at a 0.05 family-wise type I error. RESULTS: Of 47,178 individuals who meet the study criteria, 29% (n = 13,682), 12% (n = 5,829), and 59% (n = 27,667) were classified as switchers, augmenters, and maintainers, respectively. Baseline characteristics (age, gender, region, comorbidity and payer/plan-type) were similar across the three cohorts. Total post-index PPPY medical visits for switchers, augmenters, and maintainers were 26 (SD = 20.8), 28 (SD = 23.0), and 18 (SD = 17.0) for ambulatory, 1.2 (SD = 3.9), 1.4 (SD = 4.8) and 0.84 (SD = 3.3) for ER, and 0.31 (SD = 0.78), 0.32 (SD = 0.87) and 0.12 (SD = 0.46) for inpatient services, respectively. A similar pattern was observed for depression-related PPPY resource-use with higher (p < 0.0001) visits in the switcher/augmenter cohorts vs. maintainer cohort. Average total and depression-related health care costs were 1.52 to 2.06 times (p < 0.001) and 1.54 to 2.03 times (p < 0.001) greater for switchers ($8512 and $859)/augmenters ($8624 and $847) vs. maintainers ($5600 and $417) after controlling for baseline characteristics, costs and post-index adherence to antidepressants. CONCLUSION: MDD subjects that change therapy within 12-months of treatment initiation have higher resource use and costs compared to those who stay on the same therapy. Further research needs to be conducted to determine the impact on indirect costs.

PMH21
THE COST-EFFECTIVENESS OF RISPERIDONE LONG-ACTING INJECTABLE IN SWEDEN
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OBJECTIVES: Risperidone long-acting injectable (RLAI) is the only long-acting atypical antipsychotic for schizophrenia. The cost effectiveness of RLAI compared to olanzapine and haloperidol depot was analyzed in a Swedish treatment setting, using a discrete event simulation (DES) model. METHODS: Following interviews with a Swedish expert panel an existing DES model, which simulates individual schizophrenia patients over a five-year time period, was adapted to reflect schizophrenia treatment and comply with local health-economic guidelines. Inputs for the model were derived from clinical trial data, literature, database analysis and expert opinion. Cost estimates depend on treatment and treatment location; quality of life depends on symptom severity (measured by the PANSS score) and side-effects. A mul-

Abstracts