design and followed rosacea patients enrolled in North Carolina Medicaid and who were prescribed at least one study medication (topical metronidazole, adapalene, azelaic acid, permethrin, and sulfacetamide). Patients’ demographic characteristics, number of metronidazole refills, and different components of health care costs were examined. Multivariate regression analyses were used to examine factors associated with prescription refills and health care costs. RESULTS: Out of the total 2587 rosacea patients, the majority (69%, n = 1771) had 1 or more prescriptions for topical metronidazole. Most of the patients in this study were Whites (73%). After controlling for other variables, increasing age was associated with higher number of metronidazole refills and health care costs (both p < 0.001). As compared to Whites, African American patients had significantly lower number of metronidazole refills (p < 0.001). An increase in number of metronidazole refills was not associated with an increase in health care costs. CONCLUSIONS: Patients’ race was significantly associated with the number of topical metronidazole refills. Patients’ health care costs increased with increasing age and charges paid for prescriptions. Topical metronidazole seems to be an economically feasible treatment option for Medicaid-enrolled patients with rosacea.

RETROSPECTIVE CHART REVIEW TO ASSESS IMPLEMENTATION OF NICE GUIDANCE ON THE USE OF BIOLOGICAL THERAPIES IN PATIENTS WITH CHRONIC PLAQUE PSORIASIS

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OBJECTIVES: To assess the use of biologicals for psoriasis according to NICE technology appraisal 103 and assess actual treatment practice within the NHS. METHODS: To date 13 UK sites have enrolled into the chart review. Site selection was based upon recruiting three centres with prescribers of biologicals across nine geographical locations. Information was collected for patients initiated on a biological between August 2006 and December 2007 for plaque psoriasis. Patients were excluded if they had a diagnosis of psoriatic arthritis. The data was collated on demographics, co-morbidities, treatment courses, Psoriasis Area Severity Index (PASI) and Dermatology Life Quality Index (DLQI), and reasons for stopping treatment. Data was analysed to ascertain adherence to NICE, and to explore regimens used in practice and discontinuation rates. RESULTS: Recruitment is being completed. This information will be reported as a full dataset in the poster. Thus far data has been collected for 66 patients across 7 centres. The average age of patients reported was 46 years. Eight-one percent of patients were initiated on etanercept 25 mg twice weekly, 3% on etanercept 50 mg twice weekly, and 8% on efalizumab. Of those patients who initiated etanercept 25 mg twice weekly, the average length of the first course of treatment was 169 days (approximately 24 weeks). Patients discontinued etanercept treatment for various reasons including adverse events and lack of efficacy. Fourteen switched to efalizumab following first etanercept course. Many patients did not have PASI and DLQI recorded 12 weeks post treatment commencement. CONCLUSIONS: Many of the NICE criteria for prescribing biologicals have been followed; however there are some areas which require focus including recording of PASI and DLQI scores within three months. The review also showed that the intermittent dosage assumed by NICE in the appraisal of these drugs may not be realistic and modification is needed in further technology appraisals.

A SCORING SYSTEM FOR QUALITY OF CARE EVALUATION: A COMMUNITY-BASED STUDY OF CHRONIC LEG ULCERS IN NORTH GERMANY

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OBJECTIVES: Evaluation of quality of care of leg ulcers in the area of Hamburg, assessment of treatment with respect to guidelines, recording of patients’ quality of life and burden of treatment in the area of this community. METHODS: Potential criteria for the evaluation of quality of care were derived from the German AWMF-guideline and relevant international guidance. Wound experts (physicians and nurses) derived 20 priority criteria and indicators which define “optimal treatment” in a national Delphi consensus. A total score for quality of care was developed, ranging from 0–100 (no to perfect quality of care). Then, a representative sample of n = 520 patients with chronic leg ulcers of any origin was consecutively drawn. Patients were approached in wound clinics, office-based practices, nursing homes, home care services and special centres for homeless and drug addicts, thus including a large spectrum of 220 health care providers. All patients were interviewed, all wounds photographed and examined by trained wound experts. Patients were asked to fill a questionnaire addressing quality of life, prior therapy and health services/care. RESULTS: Data of 502 patients were analysed, including leg ulcers with venous (63%), mixed (23%), vasculitic (2%) and other (12%) pathogenesis. A high proportion of patients (78.6%) were treated with modern wound dressings. Pain and compression therapy was mainly in accordance with guidelines. However, deficits were detected for diagnostics (e.g. angiography, biopsies, pain measurement) and concomitant wound treatments. A high proportion of patients still had a markedly impaired quality of life. The mean total score for quality of care was below 60. CONCLUSIONS: In spite of mostly “lege artis” topical treatment, many patients in North Germany are not treated in accordance to relevant guidelines. The quality of care scoring method developed was shown to be a sensitive tool for health services research and evaluation.

IMPACT OF HEALTH CARE REGULATION ON PROSTAGLANDIN ANALOGUE PRESCRIBING IN 5 EUROPEAN COUNTRIES

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OBJECTIVES: To compare the evolution of prostaglandin analogue (PGA) and beta-blocker (BB) prescriptions in five European countries in the context of the health care regulation environment. METHODS: Data from different sources were gathered: 1) 1998–2003 prescriptions delivered by the central pharmacy of the Padova geographical area; 2) IMS data (1995–2006) from France, Germany, Italy, Spain and the United-Kingdom; and 3) an extraction of glaucoma-treated patients from the UK-GPRD. Drugs were grouped in 3 classes: PGA, BB and others. Yearly market shares were calculated. Treatment persistence survival curves were estimated from the Italian and UK data and the three drug groups were compared using the Cochran Mantel Haenszel test. RESULTS: According to the Padova data, BB market share
similar improvements of week 28 and 40, the DLQI and PASI achieved and maintained a DLQI score of 37.5% in PASI (21.4%) at week 2, with 11.4% of patients achieving a % improvement from baseline was higher in DLQI (37.5%) than PASI (21.4%). A significant correlation between the change in DLQI and change in PASI, ustekinumab was still associated with significant improvement in DLQI (p < 0.001). In general, the studies do report higher efficacy and bleed cessation rates for rFVIIa than for aPCC; however, the measurement of effectiveness of the agents is open to interpretation due to variety of methods being used to evaluate effectiveness. Further head-to-head trials should incorporate a standardized measurement for defining efficacy.

**SYSTEMIC DISORDERS/CONDITIONS—Clinical Outcomes Studies**

**A SYSTEMATIC REVIEW OF THE EFFICACY OF RECOMBINANT ACTIVATED FACTOR VII (rFVIIa) AND ACTIVATED PROTHROMBIN COMPLEX CONCENTRATE (aPCC) IN THE ON-DEMAND TREATMENT OF MINOR TO MODERATE BLEEDING EPISODES FOR HAEMOPHILIA PATIENTS WITH INHIBITORS**

**OBJECTIVES:** The primary treatment for minor to moderate bleeding disorders in haemophilia patients with inhibitors is either rFVIIa or aPCC. The efficacy of both products has been evaluated in individual studies; however there has not been an overall review and attempt to establish a valid estimate of the effectiveness of rFVIIa and aPCC. We undertook a systematic review of the literature in an attempt to establish robust estimates of efficacy, speed of bleed resolution, and adverse event profile of both rFVIIa and aPCC. METHODS: We identified 11 open-label cohort studies, six randomized clinical trials, including two head-to-head clinical trials and a meta-analysis. The definition of efficacy varies between these studies, but is usually a composite measure of definite relief of pain, reduction in the size of the haemorrhage, and cessation of bleeding. The individual making the interpretation of efficacy (i.e., the clinician, the patient/caregiver, or a combination of both) and the time from treatment initiation to the recording of the efficacy endpoint also varies across the studies. RESULTS: Overall, estimates of efficacy based on randomized clinical trials using dosing regimens in line with guidelines are higher for rFVIIa (81%–91%) than for aPCC (64–80%). Conclusions from a meta-analysis suggest that treatment with rFVIIa may be associated with a faster time to joint bleed resolution than aPCC due to higher efficacy levels at 12, 24 and 36 hour time points. The results from a comparative trial support the improved efficacy rates associated with rFVIIa compared to aPCC. CONCLUSIONS: In general, the studies do report higher efficacy and bleed cessation rates for rFVIIa than for aPCC; however, the measurement of effectiveness of the agents is open to interpretation due to variety of methods being used to evaluate effectiveness. Further head-to-head trials should incorporate a standardized measurement for defining efficacy.