levels ≥ 1.0 (7.2 ± 7.7 days vs. 5.5 ± 5.6 days) after risk adjustment— the actual to predicted LOS ratio was not significantly different from 1. CONCLUSION: The majority of cases have serum digoxin levels that are above the currently recommended range and cases with serum digoxin levels ≥ 1.0 have a higher mortality. Cases with serum digoxin levels ≥ 1.0 did not have higher risk-adjusted LOS. Digoxin dosing during hospitalization requires careful monitoring and has the potential of improving safety and related outcomes.

**PHP38**

**A QUALITATIVE REVIEW OF OFF-LABEL USES OF INTRAVENOUS IMMUNGLOBULIN**

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OBJECTIVE: The various off-label uses of intravenous immune globulin (IVIG), used for the treatment of immunodeficiency disorders, far exceeds its labeled indications. This study represents an effort to identify these uses. METHODS: Clinical studies concerning the off-label uses of IVIG preparations were identified by searching the PUBMED (MEDLINE+) database from January 1, 1998 to January 1, 2006. The search was limited to clinical trials, meta-analyses, randomized controlled trials, and case reports in English. RESULTS: A review of 138 clinical trial abstracts identified 10 trials examining 2 labeled uses (635 patients) and 128 trials examining 61 different off-label uses (6781 patients). The top off-label indications included multiple sclerosis, graft versus host disease in transplant patients, prevention of antiphospholipid syndrome in miscarriage, and Guillain-Barre syndrome. The studies appear to support many of the acceptable off-label uses cited by various guideline groups. A total of 276 case reports were identified, with 268 reports representing 156 different off-label uses (362 patients). Patient outcomes from published abstracts were positive for 267 patients (74%). Seven meta-analyses were identified, evaluating recurrent infection in preterm infants, multiple sclerosis, immune thrombocytopenic purpura, and pempighid. With the exception of recurrent miscarriage and infection in preterm infants, multiple sclerosis, immune thrombocytopenic purpura, and pempighid. With the exception of recurrent miscarriage and infection in preterm infants, the off-label use of IVIG for these indications was found to have positive outcomes. CONCLUSION: Over 130 off-label uses were identified from reviewing clinical trials and case reports. An examination of IVIG guidelines by specialty society, payer, and other review organizations shows that the biomedical evidence supporting off-label uses is being interpreted in different ways. Health care institutions are strongly urged to approve and closely monitor specific uses of IVIG to reserve dwindling supplies for the “best evidence” uses. Clinicians should be aware of the limits of knowledge in many off-label uses and exercise restraint in prescribing for unproven indications.

**PHP40**

**ANALYZING INEQUITY IN HEALTH CARE UTILIZATION BY THE US POPULATION**

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OBJECTIVE: To evaluate equity concerns in routine and preventive health care utilization. METHODS: Data from the MEPS’s Household Component (2004), a nationally representative survey of the U.S. civilian noninstitutionalized population, was used. Equity was defined on the principle of equal treatment for equal need. Need variables controlled in the model were perceived health status, presence of illness, comorbidities, activities and instrumental activities of daily living limitations. Non-need variables assessed for presence of horizontal equity were age, gender, race, ethnicity, income, and education. Need variables were studied to confirm presence of vertical equity, which was defined as different levels of need variables consuming appropriate different levels of health care. Equity in routine health care utilization namely-expenditures on Emergency room (ER), Inpatient hospitalization (IPH), Outpatient care (OPT), Office-based care (OFB), Dental care (DENTAL), and Prescriptions drugs (RX) were analyzed by GLM with log-link and Gamma/Poisson families. Binary measures of dental check-up, cholesterol check-up, blood-pressure check-up, and flu-shots, as indicators of preventive health care utilization, were analyzed by logistic and skewed-logistic models. RESULTS: Horizontal inequity was observed by age, gender, and income in all routine care variables except ER. Inequity by education was observed in OFB, DENTAL, and RX. Race related inequity was observed in OFB, IPH, DENTAL, and RX. Inequity by ethnicity was observed in utilization of all routine care variables. Necessary condition for vertical equity was not satisfied only in ER and DENTAL utilization. Horizontal inequity was observed in all four preventive care variables by age, gender, ethnicity, income, and education. Horizontal inequity by race was observed in cholesterol check-up, blood pressure check-up, and receipt of flu shots. Evidence of vertical equity was not observed in preventive care utilization. CONCLUSION: Horizontal inequity in age, gender, race, ethnic-