Abstracts

non-health resources utilization under routine medical practice derived in substantial costs when treating refractory painful due to cervical or lumbar radiculopathy. About two-thirds of the total costs were derived from non-health resources.

PPN5
LONGITUDINAL HEALTH AND NON-HEALTH RESOURCES UTILIZATION AND DERIVED COSTS OF TREATING REFRACTORY PAINFUL RADICULOPATHY IN PRIMARY CARE SETTING (PCS): A 12-WEEKS POST-HOC ANALYSIS OF THE PREGABALIN EFFECT UNDER ROUTINE MEDICAL PRACTICE

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OBJECTIVES: To analyze the Pregabalin (PGB) effect under routine medical practice on longitudinal health and non-health resources utilization (HRU) and derived costs of treating refractory painful Radiculopathy in Primary Care Setting (PCS) during 12-weeks. METHODS: A representative sample of PC centres included men and women above 18 years, with chronic pain (6-month or more) due to cervical (17%) or lumbar (83%) radiculopathy refractory to, at least, one previous analgesic [mean (SD) number of drugs: 2.6 (1.4)], in a prospective, naturalistic, 12-weeks two-visit study. Health resources included all-type medical visits, hospitalizations, complementary test and pharmacological and non-pharmacological therapies. Non-health included wages losses due to loss-work-days equivalents (LWDE = absenteeism days + days working with reduced productivity due to pain). Pain severity was measured by McGill-pain scale. Descriptive statistics and ANCOVA models were applied to compare 12-weeks periods of treatment. RESULTS: One-thousand-three-hundred-fifty-one PGB-naive patients [55.8% women, 56.7 (12.5) years] were analyzed: 490 (36%) switched to PGB as monotherapy (PGBm), 702 (52%) patients received PGB as add-on therapy (PGBadd-on), and in 159 (12%) previous treatment was replaced by a regimen not including PGB (Non-PGB). As compared to non-PGB, both PGBm and PGBadd-on showed significantly higher HRU reduction. The extra costs of drugs, particularly in PGB subgroups [€15.9 (39.1), €148.6 (109.1) and €145.3 (119.6), respectively (p < 0.0001 within and between groups)] was off-set by higher significant reductions in all other components of health costs (except non-pharmacological therapies in non-PGB group) yielding to a greater total cost reductions: €1203.3 (1805.6), €1423.2 (1650.0) and €1429.2 (1966.2), respectively (p < 0.001 within and p = 0.0004 between groups). CONCLUSION: In the primary care setting either add-on or monotherapy with pregabalin under routine medical practice was associated with a significant longitudinal reduction in HRU and total costs when compared with non-PGB therapy in subjects with painful radiculopathy of cervical or lumbar origin.

RESOURCES UTILIZATION DUE TO BREAKTHROUGH PAIN: RESULTS FROM A PROSPECTIVE STUDY ON PATIENTS WITH CHRONIC PAINFUL CONDITIONS

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OBJECTIVES: In this prospective study, we captured resource utilization and work productivity due to breakthrough pain (BTP). METHODS: The sample consisted of outpatients at a large U.S. academic medical center who had chronic pain due to headache, musculoskeletal problems, arthritis/rheumatism, and sickle cell anemia. Patients were administered a 1-week diary which captured demographics, disability, pain (10-point VAS), resource utilization due to BTP (hospitalizations, emergency room visits, outpatient visits, and calls to physician offices), and work productivity (Health-Related Productivity Questionnaire-Diary). RESULTS: Among the 161 patients enrolled, 142 reported at least 1 BTP flare during the diary week (90.5%). Of these, 36 suffered from chronic headache (25.3%), 16 from arthritis/rheumatism (11.3%), 16 from sickle cell anemia (11.3%), 9 from musculoskeletal problems (6.3%), and 1 from neuropathy (0.7%). The remainder reported 2 or more painful conditions (45.1%; n = 64). The cohort experienced 2361 BTP flares (mean per patient per week = 18). Mean pain levels were 5.3 for headache, 5.2 for arthritis/rheumatism, 6.2 for sickle cell anemia, 6.8 for musculoskeletal problems, and 6 for those with 2 or more painful conditions. BTP flares resulted in 8 hospitalizations, 9 emergency room visits, 30 outpatient medical visits, and 24 calls to physician offices during the diary week and
participants missed a total of 191 work hours due to BTP (mean = 1.9 work hours lost per participant). Many were unable to work due to disability (n = 45; 31.7%) and disability was more common in patients with 2 or more painful conditions (p = 0.004). Anxiety and depression were noted to be prevalent (22.5% reported anxiety, 24.6% reported depression, 16.2% reported both), particularly among those with headache alone or 2 or more painful conditions (p = 0.035). CONCLUSION: Patients with BTP frequently seek care to control their pain and also experience productivity loss. Anxiety and depression may add to the economic burden of BTP.

PAIN—Health Care Use & Policy Studies

PPN8
CHRONIC PAIN TREATMENT WITH OPIOIDS: PRACTICE DOES NOT FOLLOW POLICY
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OBJECTIVES: To examine the use of extended release (ER) opioids relative to immediate release (IR) opioids in chronic opioid treatment episodes. METHODS: Data from the i3 Innovus Lab/Rx Database were used in this analysis. Enrollees having at least one pharmacy claim for a combination opioid, extended release opioid or immediate release opioid between June-2003 and May-2006 and having at least one year of continuous enrollment beyond the date of their first observed opioid pharmacy claim were included in this analysis. Opioid-related treatment episodes were created by combining contiguous days of therapy allowing for a maximum of a 7-day gap between medication refills. Opioid-containing preparations were classified as either ER or IR formulations. Outcomes are reported in the form of probabilities and odds-ratios. RESULTS: A total of 3,993,011 opioid treatment episodes were derived from 1,967,898 patients. Overall, treatment episodes involving IR preparations (97.7%) are more prevalent than treatment episodes involving ER preparations (2.3%). The odds of an ER preparation being prescribed chronically (>= 60 days) was approximately 11 times that of an IR preparation, OR = 10.7. The data were further stratified by prescriber-type (designated as pain specialist or non-specialist). The probability of a pain specialist prescribing ER opioids in these chronic episodes was 19.1%; whereas the probability for non-specialists was 13.7%. In comparing the two prescriber groups, pain specialists are about 50% more likely to prescribe ER opioids relative to non-specialists, OR = 1.49. CONCLUSION: These data suggest that clinical practice does not follow accepted pain treatment guidelines for chronic pain. Further research will need to be conducted to better understand physician prescribing behaviors as they relate to chronic pain treatment and why the existence of treatment guidelines may not alone be sufficient to promote a medication regimen that will optimize pain care for appropriate patients.

PAIN—Methods and Concepts

PPN9
PERCEPTION OF BREAKTHROUGH PAIN IN PATIENTS WITH CHRONIC PAINFUL CONDITIONS
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OBJECTIVES: To understand how patients with chronic noncancer pain define and describe breakthrough pain (BTP).

METHODS: This prospective study included outpatients from a large U.S. tertiary medical center who suffer from chronic pain due to headache, arthritis/rheumatism, musculoskeletal problems, or sickle cell anemia. Data were collected using a 1-week pain diary with questionnaire that captured their perceptions of BTP. Participants were asked to choose a term that best describes a pain flare and a definition of the term they selected. Pain scores were captured using a 10-point visual analog scale (VAS). RESULTS: The study cohort included 161 patients (36 with headache, 19 with arthritis/rheumatism, 17 with sickle cell anemia, 8 with musculoskeletal problems, and 70 with ≥2 pain conditions). Most were female (80.1%), white (67.7%), and experienced BTP during the diary week (90.5%). The mean pain level reported during the diary week was 6, and the mean age was 49.3 years. The terms used to describe BTP were “pain flare” (34%), “acute pain episode” (29.1%), “pain crisis” (19.9%), “sudden new pain episode” (16.5%), and “breakthrough pain” (11.9%). There were no differences by pain source except among headache patients, where more than half (52.8%) termed BTP as “an acute pain episode.” Most commonly selected definitions for BTP were “sudden pain more than your chronic pain” (31.3%), “a period of pain worse than your controlled pain” (26%) and “a brief episode of pain more intense than your usual pain” (21.3%). There were no differences in preferred BTP definition by pain source. CONCLUSION: Patients with chronic pain prefer to use the terms “pain flare” and “acute pain episode” rather than “breakthrough pain” when referring to BTP. The concepts of “brief” and “sudden” appear to be important when defining BTP. Results will be helpful to outcomes researchers who study pain.

PPN10
LINGUISTIC ADAPTATION INTO SPANISH AND PSYCHOMETRIC VALIDATION OF THE NEUROPATHIC PAIN SCREENING QUESTIONNAIRE: ID PAIN
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OBJECTIVES: To achieve a linguistic adaptation and psychometric validation of the ID Pain questionnaire for the screening of differential diagnosis of pain with a neuropathic component. METHODS: Cross-sectional validation study carried out in two phases: cultural adaptation into Spanish language and validation study to test psychometric properties of the scale in men and women >18 years, with neuropathic (NP) and nonneuropathic (NNP) chronic pain for more than 6 months. Scale properties of feasibility, reliability and validity were evaluated according to clinical and LANNS scale reference diagnosis. Factor and ROC curves analysis, agreement with reference diagnosis and determination of sensitivity and specificity values were assessed. RESULTS: A total of 283 subjects (64.4% women; mean age: 59.1 ± 14.9 years), 145 (51.2%) with NP and 138 (48.8%) with NNP were included in the study. Time to completion of questionnaire was 4.2 (3.0) minutes, and 15% of patients needed some help to complete it only. Factor analysis showed a one-dimension scale only, explaining the 37.5% of total variance. The instrument was time-stable (test-retest r-Pearson = 0.98, p < 0.0005). Mean score differentiated NP from NNP patients; 3.5 (1.2) vs. 1.2 (1.4); p < 0.0005. Optimum cut-off value was ≥ 3.