PSM10
COMPARISON OF DISEASE STATUS AND OUTCOMES OF PATIENTS WITH PSORIATIC ARTHRITIS (PsA) RECEIVING THEIR FIRST BIOLOGIC IN UK, FRANCE, ITALY AND SPAIN (SEU)
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OBJECTIVES: To compare the disease status and outcomes of patients with PsA receiving their first biologic treatment in SEU in a multi-country multi-center medical chart-review study of PsA patients was conducted among physicians (rhematologists:97%) in hospitals and private practices to collect de-identified data on treatment patterns/dynamics and patient symptomatology/disease status.
CONCLUSIONS: Comparison of disease status and outcomes for anti-TNF therapy was conducted among PA populations with prior experience with anti-TNF agents, regardless where the criteria weights were obtained from similar or different sources. Policy implications need to be explored.

PSM12
STRUCTURING CRITERIA IN MULTI-CRITERIA DECISION MODELS FOR BENEFIT/RISK ASSESSMENT OF BIOLOGICS IN JUVENILE ARTHRITIS
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OBJECTIVES: Multi-criteria decision analysis (MCDA) is a technique which is proposed for quantitative benefit/risk assessment. MCDA structures benefits and risks in a decision or value tree, either by forming hierarchical clusters of benefits and risks separately or by placing both benefits and risks on the same level allowing direct comparison of benefits and risks (non-hierarchical).
CONCLUSIONS: The rank order of the utilities differed among stages and this was also the case if the criteria were clustered. The decision makers could therefore only reach a consensus for the first stage defining the clusters. The criteria weights for the clusters were highly dependent on the stage of the MCDA analysis. The criteria weights for the clusters were highly dependent on the stage of the MCDA analysis. Higher criteria weights were more steep and the range between most and least important criterion was larger than in non-hierarchical structures. Risks were considered more important (aggregated w=0.53) in an non-hierarchical structure than in an hierarchical structure (w=0.20). Applying the performace weights for three TNF-a inhibitors showed that there is a different rank-order of drugs being considered. The weights elicited from non-hierarchical questionaire showed Etanercept to be most preferred. Yet, Adalimumab was most preferred if a hierarchical structure was used. The non-hierarchical questionaire could be transformed to a hierarchical structure after which a similar rank-order of drugs was found as in the hierarchical structure. CONCLUSIONS: The rank order of the utilities differed among stages and this was also the case if the criteria were clustered. The decision makers could therefore only reach a consensus for the first stage defining the clusters. The criteria weights for the clusters were highly dependent on the stage of the MCDA analysis.

PSM14
ANNUAL MORTALITY IN A LARGE PREVALENCE-BASED SAMPLE OF UNITED STATES RHEUMATOID ARTHRITIS PATIENTS
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OBJECTIVES: Studies estimating mortality rates in United States rheumatoid arthritis (RA) patients have largely been based upon registry or single-center populations numbering in the hundreds or few thousands of RA patients, which limits the generalizability of their findings. The objective of this study was to describe annual mortality in a large prevalence-based sample of U.S. RA patients.
METHODS: This was a retrospective study based on mortality data obtained from the Social Security Administration's Multi-Cohort Mortality Study (SCAC). Individual-level data were linked to mortality data through the Death Master File. A total of 7,238,066 individuals present in the Truven Health MarketScan® Commercial and Medicare Supplemental administrative claims databases. The SSA data currently include up to 3 years of follow-up, and the cumulative data set was closed as of March 31, 2014. The maximum follow-up time was 15 years. The main outcome was all-cause mortality.
RESULTS: During the 2007-2014 period of follow-up, 315,073 deaths were identified. The annual age- and sex-adjusted mortality rate was 76.6 per 1,000 person-years, which corresponds to 6.9 deaths per 1,000 RA patients per year. The annual mortality rate was 9.9 per 1,000 in females compared with 6.7 per 1,000 in males. The annual mortality rate was highest in individuals aged 65-74 years and lowest in individuals aged 18-44 years, with the risk of death increasing with age. Mortality risk was also higher in individuals with a higher Charlson Comorbidity Index (CCI) score. The cumulative incidence of death was 14.0% after 2 years, 28.3% after 5 years, and 46.5% after 10 years. Mortality risk was higher in individuals with a higher CCI score, and the cumulative incidence of death was 14.0% after 2 years, 28.3% after 5 years, and 46.5% after 10 years. Mortality risk was higher in individuals with a higher CCI score, and the cumulative incidence of death was 14.0% after 2 years, 28.3% after 5 years, and 46.5% after 10 years.
CONCLUSIONS: This study confirms the high mortality risk in individuals with RA, which is similar to previous estimates. The findings of this study highlight the importance of early intervention and close monitoring of RA patients to reduce mortality risk.