objective of this research is to estimate current and future burden of this condition using the UK as an example. METHODS: Age and sex related prevalence rates have been applied to current and forecast population data to estimate future prevalence. A published assessment of patient costs is used to derive an estimate of economic burden. RESULTS: Our analysis indicates that 4.7 million people are estimated to have OAB in the UK. Although few males are treated for this disease, male prevalence is estimated to account for up to 45% of the total (treated and untreated) OAB population. UK government population forecasts for 2020 imply a 27% growth in OAB prevalence with male prevalence increasing faster than that of females. Using published data for average annual patient costs for OAB patients, the current cost burden of OAB in the UK is estimated to exceed £800m per annum. CONCLUSIONS: OAB is a highly prevalent condition imposing a substantial economic burden, which will increase with demographic shifts towards an aging population. If the prevalence of OAB risk factors including diabetes, smoking, and UTIs increases over time, then it is reasonable to expect that age related OAB prevalence will increase with time. Our forecast prevalence may therefore underestimate future burden because our analysis assumes that age related prevalence is constant over time. Assuming constant costs per patient, the economic burden will increase in line with our prevalence forecasts. Given that many sufferers, especially males, do not currently seek treatment, the future cost burden may also have been underestimated.

PUK6

THE RELATIONSHIP BETWEEN COST OF CARE AND COMORBIDITY IN CHRONIC KIDNEY DISEASE

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OBJECTIVES: Previous analyses have shown that the cost of managing chronic kidney disease (CKD) increases with worsening disease. In this study, we were interested in the relationship between cost of care, CKD and comorbidities (proteinuria, coronary artery disease, congestive heart failure (CHF), diabetes mellitus, hypertension, anemia, and hyperlipidemia). METHODS: Cases were >17 years of age, and had a GFR (estimated by MDRD) greater than 15ml/min/1.73m2 and less than 90ml/min/1.73m2 (the index GFR), followed by a second GFR below 90ml/min/1.73m2 at the first creatinine measurement that occurred at least 90 days later; controls were matched on age and gender. Four disease categories were established: Controls; 60–89 (GFR 2); 30–59 (GFR 3); and 15–29 (GFR 4). Subjects were followed for 1 year and costs were annualized and weighted by months of observation. Linear regression was used to predict costs as a function of disease category, controlling for comorbidities. RESULTS: We found that patients with early and mild chronic kidney disease (GFR 30–89) consume approximately $2000 more per year in medical care than their age- and sex-matched control patients without recognized kidney disease after adjusting for comorbid conditions, while those with severe disease (GFR 15–29) consume more than twice that amount. Of the comorbid conditions that we evaluated, anemia, congestive heart failure, and proteinuria were among the strongest independent predictors of total medical costs. These conditions also modified the total cost for each stage of chronic kidney disease. CONCLUSION: Patients with CKD have a greater total cost of care than age and gender matched controls, even after controlling for CKD-related comorbidities. Combined with increasing incidence of kidney disease, these data strongly argue the need for better understanding of cost-effective treatment programs in CKD.

PUK7

A COST EVALUATION OF CYCLOPHOSPHAMIDE PLUS PREDNISONE VERSUS AZATHIOPRINE PLUS PREDNISONE FOR TREATMENT OF LUPUS NEPHRITIS

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OBJECTIVE: The best therapeutic approach to treating lupus nephritis (LN) remains contentious; therefore different therapeutic approaches have been embraced over the years. The purpose of this pharmacoeconomic decision analysis is to compare the use of intermittent intravenous cyclophosphamide plus prednisone versus oral azathioprine plus prednisone for the treatment of LN and to determine which regimen is more beneficial in terms of cost. METHODS: The third party payer perspective was used to estimate the costs of treating LN, after deciding to prescribe either regimen. Costs were obtained from various sources including primary literature and clinical trials. Analyses were based on actual costs for treatment of LN and