Abstracts

protein restriction slows the progression of kidney disease delaying the dialysis treatment. The cost of treatment of end-stage renal disease is high and increases with age. Therefore, delaying the start of renal replacement therapy with hemodialysis and improving the patient’s quality of life are two primary goals justifying the use of protein-restricted diets. The aim of the study was to evaluate the economic impact of a low-protein diet (0.6 g proteins/kg, body weight/day) with the intent of delay the haemodialysis treatment in patients with advanced chronic-renal failure. METHODS: The study was a naturalistic, longitudinal retrospective Cost of Treatment study. Patients were enrolled during the 2005 and followed up until 2007 or the beginning of haemodialysis treatment. Direct health care resources attributable to disease management (drugs, ambulatory care, day case treatments, hospitalizations, specialist visits, diagnostics and laboratory exams) were quantified using National Health Service (NHS) tariffs expressed in Euro 2008. NHS perspective was adopted. Health-related quality of life information were also collected using SF-36 questionnaire at the enrolment and at the end of the observation period. RESULTS: We enrolled 30 patients (males 60%, mean age of 56.5 ± 13.9 y.o.) from the Nephrology Department of the University “Federico II” of Naples, with a mean follow-up of 12.7 ± 7.5 months. The average monthly cost of care was €1075.6 ± 925.2 per patient, mainly because of hospitalization which represented the 45.0% of the expenses. SF-36 results showed a quality of life stable during the observation period and quite similar to the general population. CONCLUSIONS: This is the first study evaluating the economic impact of low-protein diet in patients with CRF in Italy. The protein-restricted diets helps to delay initiation of haemodialysis sessions, which substantially increase treatment costs and negatively impacts quality of life.

PUK11
A COST-UTILITY ANALYSIS OF SOLIFENACIN 5 MG AND SOLIFENACIN 10 MG VERSUS TOLERODINE ER 4 MG IN THE PHARMACOLOGICAL TREATMENT OF PATIENTS WITH OVERACTIVE BLADDER (OAB)
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OBJECTIVES: The aim of this study was to assess the cost-effectiveness of solifenacin (5 mg/10 mg) relative to tolerodine ER 4 mg in the treatment of patients with overactive bladder (OAB), from the perspective of the UK (NHS) health care system.
METHODS: This was a cost-utility analysis based on a one-year decision-tree model. A systematic review and meta-analysis. Treatment success was defined separately for urgency, frequency and incontinence. Definitions of treatment success were no urgency episodes, eight or fewer micturitions and no incontinence episodes per 24 hours. Incremental cost-effectiveness ratios (ICERs) were estimated separately for each symptom. Treatment persistence rates for solifenacin and the percentage of patients requiring the higher-dose formulation of solifenacin were taken from the DIN-LINK database. In the absence of these data for tolerodine, in the base case analysis treatment persistence and the percentage of patients requiring the higher dose formulation of tolerodine were assumed to be equal to that for solifenacin. Utility values for the calculation of Quality Adjusted Life Years (QALYs) were taken from published sources. The analysis included costs directly associated with OAB treatment, i.e. antimuscarinic therapy, GP consultations and outpatient contacts; cost data were taken from NHS published sources (2007/2008 prices). Resource utilisation was based on expert opinion. RESULTS: In the base-case analysis, solifenacin resulted in a cost-effective treatment strategy compared with tolerodine for urgency and frequency outcomes being both more effective and less costly. Tolerodine was more effective but more expensive than solifenacin for incontinence, with an ICER of £84,686/QALY. CONCLUSIONS: This analysis suggests that tolerodine does not provide a cost-effective treatment option relative to solifenacin at a cost-effectiveness threshold of £30,000/QALY for the resolution of urgency, frequency and incontinence in patients treated for OAB.

PUK12
A COST-UTILITY ANALYSIS OF SOLIFENACIN 5 MG AND 10 MG VERSUS FESOTERODINE 4 MG AND 8 MG IN THE PHARMACOLOGICAL TREATMENT OF PATIENTS WITH OVERACTIVE BLADDER (OAB) IN THE UK NHS
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OBJECTIVES: The aim of this study was to assess the cost-effectiveness of solifenacin (5 mg/10 mg) relative to fesoterodine (4 mg/8 mg) for OAB, from the perspective of the UK (NHS) health care system.
METHODS: A cost-utility analysis was undertaken using a one-year decision-tree model. Estimates for clinical effectiveness were obtained from a systematic review and meta-analysis. Treatment success was defined separately for urgency, frequency and incontinence. Definitions of treatment success were no urgency episodes, eight or fewer micturitions and no incontinence episodes per 24 hours. Incremental cost-effectiveness ratios (ICERs) were estimated separately for each symptom. Treatment persistence rates for solifenacin and the percentage of patients requiring the higher-dose formulation of solifenacin were taken from the DIN-LINK database. In the absence of these data for fesoterodine, in the base case analysis treatment persistence and the percentage of patients requiring the higher dose formulation of solifenacin were assumed to be equal to that for solifenacin. Utility values for the calculation of Quality Adjusted Life Years (QALYs) were taken from published sources. The analysis included costs directly associated with OAB treatment, i.e. antimuscarinic therapy, GP consultations and outpatient contacts; cost data were taken from NHS published sources (2007/2008 prices). Resource utilisation was based on expert opinion. RESULTS: In the base-case analysis, solifenacin resulted in a cost-effective treatment strategy compared with fesoterodine for urgency and frequency outcomes being both more effective and less costly. Fesoterodine was more effective but more expensive than solifenacin for incontinence, with an ICER of £84,686/QALY. CONCLUSIONS: This analysis suggests that fesoterodine does not provide a cost-effective treatment option relative to solifenacin at a cost-effectiveness threshold of £30,000/QALY for the resolution of urgency, frequency and incontinence in patients treated for OAB.

PUK13
EXPANDED CRITERIA DONORS IN RENAL TRANSPLANTATION: RESULTS OF ECONOMIC EVALUATION
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OBJECTIVES: At present, expanded criteria donors suppose up to 40–50% of the renal transplant. The aim was to evaluate cost-utility difference between standard criteria donors (SCD) versus expanded criteria donors (ECD) at the first year of kidney transplant. METHODS: Patients were collected in the waiting-list for renal transplant in our region from January 1, 2003 to December 31, 2005. Clinical and demographic variables, transplant costs and EQ-5D tariff, as a generic perceived state of
A HEALTH ECONOMIC EVALUATION OF THE USE OFERYTHROPOIESIS-STIMULATING AGENTS (ESA) IN PATIENTS WITH RENAL FAILURE TREATED WITH HAEMODIALYSIS

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OBJECTIVES: To assess the cost and the resource use related to anaemia management with Aranesp®, Eprex® and Neorecormon(r) in patients with chronic renal failure treated with haemodialysis in Belgium; and to assess the effect of anaemia management on haemoglobin (Hb) levels. METHODS: Data on anaemia management and resource utilization were collected using a retrospective chart review conducted in 11 haemodialysis centres distributed across Belgium. From each centre between 30 and 40 patients were randomly selected. Data on drug use, transfusion, consultations, hospitalizations, diagnostic tests and Hb level were collected over a 1-year study period (1 December 2005 until 30 November 2006). The costs were calculated by multiplying each item of resource use with its unit cost (in 2007; in €) from the Belgian health care payer’s perspective (RIZIV/INAMI). RESULTS: A total of 335 patients were included of which 105, 132 and 98 were treated with Aranesp®, Eprex® and Neorecormon(r), respectively. There were no demographic differences between the treatment arms. There were no statistically significant differences between the 3 ESAs in the total annual anaemia management cost in haemodialysis treated chronic renal failure patients despite differences in drug list prices between the 3 ESAs. The cost ranged from €8203 to €9281. There were no significant differences in the average weekly dose of ESA between the 3 drugs. Independent of the iron status of the patient, or whether stratified by CRP level, the percentage of patients reaching a Hb level ≥ 11 g/dl was similar in the 3 treatment arms and ranged from 76% to 81%. CONCLUSIONS: In patients with chronic renal failure, treated with haemodialysis, there were no significant differences between the 3 available ESAs in medical resource use, average dose of ESA needed, annual anaemia management costs from the perspective of the Belgian public health care payer and in Hb control.