OBJECTIVES: Chronic immune thrombocytopenia (ITP) is characterized by low platelet counts and an increased risk of bleeding-related episodes (BRE). The study purpose was to estimate the cost of BREs in the US. METHODS: A BRE includes rescue medication use, a bleeding event, or both. The BRE endpoint was modeled to be cost saving overall and in 99.7% of subgroups considered.

RESULTS: The estimated costs of a mild, moderate, and severe BRE were $112, $10,737, and $21,871; with a weighted average BRE cost of $4,703, and an average annual cost of $8,465 (platelets $50 x 10^9/L) and $94,473 (platelets $50 x 10^9/L). In sensitivity analyses, the cost of immunoglobulins was the most important variable; a ±50% change in cost (or dose) resulted in ±41% change in cost, particularly in ITP patients with platelet counts lower than <50 x 10^9/L.

OBJECTIVES: This study extrapolates via a simplified decision tree the economic impact of DB postsurgical pain control for up to 72 hours while reducing the need for opioids. (DB) have shown that a single injection into the surgical site provides

RESULTS: Of the 11 colectomy/cholecystectomy models, the excess cost per patient with ORAE ($4,707) was $112, $10,737, and $21,871; with a weighted average BRE cost of $4,703, and an average annual cost of $8,465 (platelets $50 x 10^9/L) and $94,473 (platelets $50 x 10^9/L). In sensitivity analyses, the cost of immunoglobulins was the most important variable; a ±50% change in cost (or dose) resulted in ±41% change in cost, particularly in ITP patients with platelet counts lower than <50 x 10^9/L.

OBJECTIVES: To compare medical expenditure and effectiveness of different therapies in chronic myeloid leukemia patients who failed in the first-line imatinib treatment. METHODS: A structured questionnaire was designed to collect information on the clinical experience of different therapies (nilotinib, imatinib dose-escalation, and allosCT) and the choices of the second-line therapies for the patients who failed in the first-line imatinib treatment included nilotinib, imatinib dose-escalation and allo-SCT. RESULTS: The choices of the second-line therapies for the patients who failed in the first-line imatinib treatment included nilotinib, imatinib dose-escalation and allo-SCT. The cytogenetic response of nilotinib was always higher than imatinib dose escalation. After 1.1-5.5 years, the cumulative cytogenetic response rate of nilotinib could be as high as 80%, which is significantly higher than that of imatinib. The most common adverse effects of nilotinib included hematologic toxicities (anemia, thrombocytopenia and neutropenia), hyperbilirubinemia, prolongation of QT interval, liver injuries, skin alterations, edema, jaundice and gastrointestinal disturbance. In parallel, bone marrow suppression is the most frequent toxicities of imatinib dose escalation treatment. Other non-hematologic adverse effects included fluid retention, gastrointestinal disturbance, muscular cramp and bone and joint pain. The expenditure of nilotinib and dose-escalated imatinib therapies was quite similar, and significantly higher than that of first-line imatinib treatment. CONCLUSIONS: It is strongly suggested that nilotinib treatment should be considered as standard treatment of imatinib-failed patients in China.