DEVELOPMENT OF AN OPIOID ROTATION MODEL
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OBJECTIVE: To develop a model characterizing the phenomena of opioid rotation for chronic non-cancer pain. METHODS: Literature review, supplemented by a panel of two pain specialists and one oncologist completed a questionnaire to provide guidance on the typical treatment pathway of care for patients requiring chronic long acting opioids for chronic non-cancer pain. Guidance included management of commonly reported side effects, frequency of follow up, dose adjustment and switch criteria. RESULTS: A model reflecting three treatment arms was constructed based on feedback from the panel: 1) MS Contin ER switch to OPAKA ER, 2) MS Contin ER switch to OxyContin ER, 3) and OPAKA ER switch to OxyContin ER for patients where morphine is not an appropriate first line treatment option. Clinicians will evaluate the effectiveness and safety within 7–14 days to determine the need for drug switch or dose adjustment. If a dose adjustment or medication switch is required, further follow up within 7–14 days will take place. Most patients’ pain is likely to be controlled with tolerable side effects within the first 28–42 days of initiation of therapy. For patients not controlled, dose adjustment, switching or consultation with a pain specialist may be required. Over the course of one year, up to 50 different pathways were possible for each treatment arm which may include two or more different opioids and up to five dose adjustments. CONCLUSION: Opioid rotation is not well characterized. Switching medications, adjusting dose and frequent follow-up, contribute to incremental costs. Appropriate selection of second or third line therapy should include consideration for patient tolerability. Further analysis from a long-term registry currently underway may provide further guidance for validating the proposed model in order to better evaluate the cost impact of switching, frequency of physician contacts, and dose adjustments associated with opioid rotation.

DIAGNOSIS AND TREATMENT FLOWS FOR MORBIDLY OBESE PATIENTS VISITING PHYSICIAN OFFICES IN THE US
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OBJECTIVE: To understand the relationship between morbidly obese patients’ reasons for office visits, physicians’ diagnoses of obesity, and obesity treatments, using a patient flow model. METHODS: We used the 2003 National Ambulatory Medical Care Survey, a nationally representative survey of visits to non-federal office-based physicians, including specialists. Patients with body mass index (BMI) >40 were categorized as morbidly obese, based on office-recorded height and weight. We created a patient flow model to study obesity diagnosis rates based on patients’ stated reasons for visit, and obesity treatment rates based on type of diagnosis. Reported percentages are based on weighted frequency counts. RESULTS: In 2003, there were 962.7 million office visits by non-pregnant adults (≥18 yrs) of which 38.7% had both height and weight recorded. Of these, 24.1 million (6.3%) visits were made by morbidly obese patients. Less than 5% stated weight gain as a reason for visit. The rate of physician diagnosis of obesity was 12.0%, with an additional 38.6% noted (but not diagnosed) as obese, leaving 49.4% neither diagnosed nor noted as obese. Obesity diagnosis rates greatly improved when patients stated weight gain as a reason for visit (81.5%). Overall only 2.1% received an obesity prescription, 38.7% received health education for weight reduction, diet/nutrition or exercise, and 59.2% received none of the above. Treatment rates improved significantly with an obesity diagnosis, with 4.2% receiving an obesity prescription and 80.1% receiving health education. CONCLUSION: Among morbidly obese patients, the rate of physician diagnosis and treatment is very low. However, rates improve when patients state weight gain as a concern. These patient flows clearly demonstrate that both the patient and physician have a shared responsibility in addressing the condition and efforts are needed to further involve both stakeholders in tackling the obesity epidemic.

RESEARCH ON METHODS & CONCEPTUAL PAPERS—Clinical Outcomes Studies
PROJECTS

SEARCH STRATEGIES AND RESULTS OF SYSTEMATIC REVIEWS
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OBJECTIVE: A systematic review is the preferred approach for assembling clinical evidence. The gold standard for literature searching comprises sensitive search strategies applied to multiple literature databases and hand-searching of journals and conference abstracts. As a follow-up to a previous ISPOR poster, we sought to evaluate the impact of different search approaches on the pooled statistical results from systematic reviews, rather than simply numbers of studies included. METHODS: Previously, we selected a series of published Cochrane systematic reviews and compared the effect of more limited search strategies (a search of multiple literature databases without grey literature, and a Medline keyword search) on the number of included studies. We extended this work to compare the pooled effect sizes resulting from meta-analyses of key outcomes from the studies included in each search strategy. The reviews covered five different areas: smoking cessation, non-small cell lung cancer, neuropathic pain, acupuncture and Crohn’s disease. All meta-analyses where studies were missed by lower level searches were re-run including only the studies retrieved by these searches. This allowed the impact of missing studies on the meta-analysis result to be assessed. RESULTS: Differences between meta-analysis results were generally fairly minimal, although in some cases missing studies changed the result of a meta-analysis from a significant to a non-significant result. In several cases lower level searches resulted in there being no studies at all looking at particular outcomes. For example, in a review of neuropathic pain treatments, which showed a significant effect of antidepressants versus placebo on atypical facial pain relief (RR 1.67), both studies included in the meta-analysis were absent when searching with a Medline keyword search only. CONCLUSIONS: A comprehensive search strategy is needed to retrieve all relevant studies in a systematic review. Less comprehensive searches impact results of meta-analyses and can distort the evidence base.

WHEN ARE INDIRECT AND MIXED TREATMENT COMPARISONS BIASED? A GRAPHICAL EXPLANATION WITH DAGS
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In the absence of head-to-head randomized studies, often indirect treatment comparisons are performed for reimbursement sub-