OBJECTIVES: To analyze the cost of hemodialysis (HD) and peritoneal dialysis (PD) in different regions of Russia. METHODS: Open source information search. Direct cost analysis. RESULTS: During the information search current tariffs have been found for 25 regions for HD and for 11 regions for PD. Tariff per one HD procedure has ranged from $96 for the republic Chuvashia to $319 for the Khanty-Mansi Autonomous Area. Annual cost of the HD per patient amounted to $14576 and $49764, respectively. The cost of a single procedure HD in Moscow was $162, which corresponds to an annual expenditure of approximately $25272 per patient. The average cost of the procedure HD in the Russia amounted to about $1 560 and the annual cost of HD for one patient - $3 2400. The cost of one exchange PD ranged from $15 in the Nizhny Novgorod region to $84 in the Khanty-Mansi Autonomous Area. Thus, the annual costs on the PD upon 4 exchanges per day for per patient in these regions were $21800 and $122840, respectively. The cost of one PD exchange in Moscow was $26, which corresponds to an annual expenditure of approximately $37960 per patient. The average cost of one exchange PD in Russia was $4938, and PD per year was $19752. RESULTS: In multivariate analysis, DGF was an independent predictor of hospitalization for patients with moderate-to-severe LUTS/BPH if symptom relief is insufficient with monotherapy. We evaluated the cost and resource utilisation, in the Markov model with a 5-year time horizon scenario, monotherapy, tolterodine (modified release, 4mg) + tamsulosin given concomitantly, and fixed-dose combination (FDC) of solifenacin 6mg + oral controlled absorption system (OCAS™) formulation of tamsulosin (TOCAS, 0.4mg). METHODS: A Markov model, with a time horizon of 1 year, was developed for men with LUTS/BPH who have moderate-to-severe storage symptoms (≥2 micturition/day and ≥2 urgency episodes/day [Patient Perception of Intensity of Urgency Scale, grade 3 or 4]) and voiding symptoms treated with FDC solifenacin 6mg + TOCAS versus tolterodine + tamsulosin. Treatment success was defined using the Total Urgency and Frequency Score (TUFs, the daily sum of all recorded Patient Perception of Intensity of Urgency Scale [PPIUS], grade 3 or 4]) and voiding symptoms treated with FDC solifenacin 6mg + TOCAS versus tolterodine + tamsulosin ($21 per patient/year) was principally due to improved persistence with FDC solifenacin 6mg + TOCAS.

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COST-EFFECTIVENESS OF A FIXED DOSE COMBINATION OF SOLIFENACIN AND TAMMSULOSIN IN MEN WITH CLINICAL Storage SYMPTOMS (LUTS) ASSOCIATED WITH BENIGN PROSTATIC HYPERPLASIA (BPH)

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OBJECTIVES: Combination therapy with an α-blocker and an antimuscarinic is recommended for men with moderate-to-severe LUTS/BPH if symptom relief is insufficient with monotherapy. We evaluated the cost-effectiveness of fixed-dose combination (FDC) solifenacin 6mg + oral controlled absorption system (OCAS™) formulation of tamsulosin (TOCAS, 0.4mg) versus tolterodine (modified release, 4mg) + tamsulosin (0.4mg), for given concomitantly, from the perspective of the UK NHS. METHODS: A Markov model, with a time horizon of 1 year, was developed for men with LUTS/BPH who have moderate-to-severe storage symptoms (≥2 micturition/day and ≥2 urgency episodes/day [Patient Perception of Intensity of Urgency Scale, grade 3 or 4]) and voiding symptoms treated with FDC solifenacin 6mg + TOCAS versus tolterodine + tamsulosin. Treatment success was defined using the Total Urgency and Frequency Score (TUFs, the daily sum of all recorded Patient Perception of Intensity of Urgency Scale [PPIUS] scores from micturition diaries). The phase 3 NEPTUNE study was used to estimate transition probabilities and utilities were derived from analysis of EQ-5D-30 data. Other model input parameters included discontinuation rates, derived from a large UK database study (TRIN). Univariate and probabilistic sensitivity analyses were performed. RESULTS: FDC solifenacin 6mg + TOCAS was associated with lower total annual costs ($520 vs $588) and increased quality adjusted life years (QALYs, 0.840 vs. 0.838), and was therefore dominant compared with tolterodine + tamsulosin. Transition, discontinuation/withdrawal rates, drug cost and utility values were the main drivers of cost-effectiveness. The probability that FDC solifenacin 6mg + TOCAS is cost-effective was 100% versus tolterodine + tamsulosin, at a willingness to pay threshold of £20,000/QALY gained. CONCLUSIONS: FDC solifenacin 6mg + TOCAS is dominant compared with tolterodine + tamsulosin. It is effective in men with LUTS/BPH who have moderate-to-severe storage symptoms and voiding symptoms. To our knowledge, this is the first cost-effectiveness analysis of a FDC in this patient population.

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ECONOMIC EFFECTS OF TREATMENT OF CHRONIC KIDNEY DISEASE WITH LOW-PROTEIN DIET

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OBJECTIVES: The most recent literature has shown extensively that a low protein diet in patients with Chronic Kidney Disease (CKD), delays the natural progression of the end stage renal disease (ESRD) and the necessary treatment of chronic dialysis. The aim of this study is to estimate the cost-effectiveness of a low protein diet compared with no diet/treatment in patients with CKD stage 4 and 5 after 2, 3, 5 and 10 years. METHODS: It was developed a Markov model to estimate costs and QALYs associated with low protein diet versus no treatment for patients with CKD stage 4-5. The transition probability was estimated on data from seven studies which were determined the annual rates of death and progression to ESRD. The model also need to start maintenance dialysis. Utilities and cost were estimated from literature review and projected for the lifespan considered in the model. The annual cost of maintenance patient was approximately £270. The annual cost of maintenance patient was £1,440 per patient per year in the Lazio Region (conservative assumptions). Probabilistic and Deterministic sensitivity analysis were performed. RESULTS: The model estimate that low-protein diet should be more effective. Dietary treatment improves mean QALYs by 0.19 after 2 years, 0.34 after 5 years and up to 0.93 incremental QALYs after the first 10 years. After two years the model estimate incremental cost in favour of dietary treatment of £1,525, £3,023, £6,906 and £13,829 for 2, 3, 5 and 10 years of follow up respectively. CONCLUSIONS: The results of these simulations indicate that the treatment of CKD patients with a