seizures was estimated for each month of follow-up for ST patients using data on inter- and intra-patient variability in seizure frequency. Seizure-days for pregabalin patients were estimated by applying the seizure-rate reduction observed in clinical trials to the estimated rate for ST. Health-state utilities were estimated using data from a survey of RPE patients. Costs of antiepileptic drugs were estimated using published US prices. Cost-effectiveness was calculated alternatively in terms of incremental cost per SF day gained and incremental cost per QALY gained. RESULTS: Compared to ST alone, add-on therapy with pregabalin 300mg/d was estimated to yield an average of 41.4 additional SF days and 0.027 additional QALYS over one year; corresponding estimates for pregabalin 600mg/d were 48.6 additional SF days and 0.030 additional QALYS. Incremental cost (mean, 95% CI) per SF day gained was $30 ($24, $39) for pregabalin 300mg/d, and $25 ($21, $29) for pregabalin 600mg/d. Corresponding estimates of the incremental cost per QALY gained were $46,055 ($35,212, $66,992) and $40,638 ($32,016, $50,616). CONCLUSION: The cost-effectiveness ratio for pregabalin as an adjunct to ST in RPE patients falls within accepted published thresholds and compares favorably to those of other add-on antiepileptics.

PNL15

COST OF ILLNESS FOR ADULTS WITH PARTIAL EPILEPSY IN SWEDEN
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OBJECTIVES: To estimate the socio-economic cost and health-related quality of life (HRQL) for adults with partial epilepsy in Sweden during 2003. METHODS: 292 patients were randomly selected from two tertiary centres (University hospital in Lund and Umeå) and complete data was obtained from 175 patients. Patients completed a 3 months prospective seizure diary, one retrospective and one prospective health care resource utilization questionnaire (3 months each). HRQL data were collected using EQ-5D and a disease-specific instrument, QOLIE-31. In addition, data was collected by physicians/nurses by a one-year retrospective patient chart review. Patients were categorized by most common seizure (sz) type (simple partial, complex partial, secondary generalized) and sz frequency (sz free, <1sz per month, >1sz per month). Direct and indirect costs were estimated using prevalence and bottom-up approach. Direct costs included inpatient care, outpatient care, pharmaceuticals and social services. Indirect costs were calculated based on the human capital theory as loss of production due to temporary sick leave and early retirement. RESULTS: The mean total annual cost per patient due to partial epilepsy was approximately 100,000 SEK, indirect costs accounting for approximately 60%. Disease-specific costs varied between 50,000–170,000 SEK depending on sz type and frequency. The mean total annual cost per patient based on all data collected for the patient population was 250,000 SEK, indirect costs accounting for approximately 50%. The patient population cost varied between 100,000–420,000 SEK depending on seizure type and frequency. Patients with complex partial seizure carried the highest cost and had the lowest HRQL. Patients with no or occasional seizures reported higher HRQL than patients with more than one sz per month. CONCLUSIONS: Partial epilepsy is a serious and expensive disease. The socio-economic cost increases and HRQL deteriorates with high seizure frequency increasing frequency of seizures and with frequent complex partial seizures.

PNL16

ECONOMIC BURDEN OF PAIN DUE TO MULTIPLE SCLEROSIS IN CANADA
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OBJECTIVES: Multiple Sclerosis (MS) is an unpredictable, chronic neurological disease with a prevalence in Canada of 0.24%. Prevalence of associated pain ranges from 10%–80% with an average of about 50%. Pain can be musculoskeletal or nerve related and affects patients’ quality of life. We estimated the prevalence and the burden of pain due to MS in Canadian MS patients from the perspective of society. METHODS: The study protocol was approved by a central Institutional Research Board and by participating hospitals. 297 patients were recruited either through MS clinics or the MS Society. Resource utilization data over the previous six months were collected by telephone interviews with the patients for direct (drugs, physicians, hospitalizations) and indirect costs (time loss). Indirect costs were based on time loss using the Canadian average industrial wage. Costing was calculated with Ontario prices and fee schedules, applying 2004 Canadian dollars (SCAD). Mean cost per patient was determined (SD, range etc.). The burden was extrapolated to the Canadian population using national demographics and prevalence rates for MS and pain in MS. Spearman’s Rho assessed the relationship between cost and pain severity. RESULTS: The average age was 49 (±11) years, with 77% females. The prevalence of pain due to MS in this study sample was 71% (211/297). The mean total direct cost per patient for pain in MS over a 6-month period was $2528 (SD = $5695), with hospitalization as the highest contributor (mean = $711). The mean total indirect cost for the same period was $669 (SD = $875). We observed a positive trend between cost and pain severity measured by the BS-11 scale (Rho = 0.291, p = 0.0001). The projected six-month burden for Canada was $65,034,679. CONCLUSIONS: Pain due to MS in Canada is associated with substantial costs to patients and society.

PNL17

ECONOMIC COSTS OF CHRONIC PRIMARY INSOMNIA IN THE UNITED STATES
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OBJECTIVE: Insomnia affects patients’ quality of life and workplace productivity, and is a risk factor for costly acute events and chronic diseases. Existing data on the costs of insomnia are sparse and outdated. Accordingly, in this study we estimated current societal and employer costs of chronic primary insomnia in the U.S. METHODS: Prevalence-based cost-of-illness estimation techniques and data from secondary sources were used to assess the economic burden of chronic primary insomnia (i.e., insomnia that is not due to a medical, psychiatric, or environmental cause) in the U.S. population. Costs included insomnia medications, insomnia-attributable health events and chronic conditions (i.e., depression, alcohol abuse, nicotine dependency, drug abuse, accidental injuries), and lost productivity. The cost of each insomnia-attributable health consequence was estimated by multiplying its total cost by its population attributable risk, which is a function of the prevalence of chronic