was to collect, in routine clinical practice, data about consequences of switching from intravenous (IV) EPO to IV in patients (pts) with chronic kidney disease (CKD) (50% of patients had ≤ 24 months of treatment). METHODS: This French monocentric observational study included adults with CKD receiving dialysis switched from EPO to DA in July 2010. Data related to EPO and DA dosing and dose frequency, Hb levels, and iron statuses were collected retrospectively over 36 weeks before the conversion and 36 weeks after the conversion. The primary endpoint estimated the dose conversion ratio (DCR) between mean EPO doses (UI) and DA (µg) during 4 weeks pre-conversion and 21-24 weeks post-conversion. The mean DCR was determined with a regression-based method using ordinary least squares (LSQ). RESULTS: A total of 11.2 patients were included in this study: 61.3% female, mean age 70.3 years (mean time on dialysis 5.2 years). The primary etiologies of CKD were mainly diabetes (37.6%) and hypertension (12.9%). The arithmetic mean (± SD) EPO dose/ injection at inclusion was 4193 ± 3417 UI with the following injection frequency: x2/week (44.1%), x2/week (23.3%), x1/week (21.5%) or other (2.1%). The mean (± SD) DCR on the evaluable population (83 patients, 10 excluded due to missing data) was 271.3 ± 30.4 (95% CI 264.7, 277.9). The mean (± SD) Hb values were equivalent over the pre- and post-conversion periods 11.2 ± 0.9 and 11.1 ± 1.0 g/dL, respectively. Iron status was also similar. CONCLUSIONS: In routine clinical practice, the mean DCR observed in our French dialysis centre, was higher than the factor 200UI:

**PUC2**

**EVALUATING THE MINIMUM RENAL ALOLOGRAFT SURVIVAL TIME REQUIRED FOR TRANSPLANTATION TO REMAIN COST SAVING IN THE UK**

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OBJECTIVES: Kidney transplantation is perceived to be highly cost effective, the cost of post-transplant management is modest compared to dialysis and quality of life is significantly improved. While graft survival rates have improved substantially in recent years, on average, graft failure rates are currently 2.9% per annum across the UK. The objective of this study was to quantify the minimum graft survival time required for transplantation to remain cost saving compared to dialysis.

METHODS: We utilized a simple decision analytic model with published input costs for dialysis, immunosuppression and other post-transplant management costs were obtained from the PORTRAIT Study (a retrospective observational study of renal transplant patients) and UK NHS reference costs used for transplantation. We estimated the number of years of functioning graft required for transplantation to remain cost saving. Future costs were discounted at 3.5%.

RESULTS: Over a 10 year time horizon the total per-patient costs associated with remaining on dialysis was £394,379, over the same period the total per-patient cost for a functioning graft is estimated to be £267,194/week and £133-182/week respectively. CONCLUSIONS: The use of CERA in patients with CKD on hemodialysis at the compensatory stage instead of shorter acting EPOs saves about 5-35% of cost for anaemia pharmacotherapy. The effectiveness and safety of therapy do not change.

**PUC5**

**PATTERNS OF TREATMENT FAILURE AMONG PATIENTS RECEIVING ANTICHOLINERGICS FOR OVERACTIVE BLADDER (OAB) TREATED IN A MANAGED CARE SETTING**

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OBJECTIVES: Previous research has described treatment failure as discontinuation of the first anticholinergic or switching in persons with continuous anticholinergic use. Such research does not account for persons who may restart anticholinergic use following a period of discontinuation. The objective of this study was to evaluate the dynamics of treatment failure in patients with OAB following discontinuation of the first anticholinergic. METHODS: Patients in a US commercial database between January 2005 and June 2010 with ≥ 1 filled prescription for an anticholinergic for OAB were included. Treatment failure was defined as patients who discontinued therapy (treatment gap of ≥ 45 days) or switched medications. RESULTS: There were 185,586 patients who met all inclusion criteria. Treatment failure was present in a total of 83.4% patients, with 78.3% of patients discontinuing first anticholinergic therapy and 5.1% of continued users switching. A total of 30.4% of persons who discontinued treatment rechallenged after the 45 day treatment gap, with 66.7% resuming treatment with their original anticholinergic. Overall, 54.5% of patients who discontinued anticholinergic therapy permanently within the one year study period. A total of 14.1% of patients switched at least once throughout the study, and patients received an average of 1.2 (SD: 0.6) unique anticholinergic agents. Of those who initially switched to a second anticholinergic, 69.6% of patients failed treatment for a second time either by discontinuing treatment (48.8%) or switching to a third agent (20.8%). A separate analysis requiring ≥ 2 fills found that 85% of patients who switched also discontinued within the one year study frame. Persons on sustained release anticholinergic were less likely to experience treatment failure than those on immediate release anticholinergics (odds ratio: 0.78 [0.76-0.80], P < 0.0001). CONCLUSIONS: Treatment failure was high in patients taking anticholinergics for OAB even after taking restarts into account. Most patients who switched from their first anticholinergic therapy experienced a second treatment failure.

**RESEARCH POSTER PRESENTATIONS – SESSION IV**

**RESEARCH ON METHODS**

**PB31**

**KAPLAN-MEIER SURVIVAL CURVES: A POTENTIAL SOURCE OF DATA FOR SYSTEMATIC REVIEWS**


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OBJECTIVES: Kaplan-Meier (KM) survival curves are commonly used to report time-to-event outcomes like overall survival (OS) and progression-free survival. For studies not explicitly reporting hazard ratio (HR) and confidence intervals (CI), KM curves can be utilized to estimate these summary statistics for conducting a meta-analysis. However, it is not clear how KM curves should be used for this purpose. METHODS: We compared how KM survival curves can be used for estimating HR (95%CI) by reading the KM curves. METHODS: Ten randomised controlled trials reporting HR (95%CI) and the associated KM curve for OS were randomly selected.