HOSPITAL COST FOR TREATMENT OF PATIENTS WITH PEPTIC ULCER BLEED (PUB) IN SWEDEN—DATA FROM THE KPP (COST PER PATIENT) DATABASE

**OBJECTIVES:** Treatment with esomeprazole or placebo was investigated in patients with PUB (NCT00251997). In all, 102 of 764 patients from 16 countries in Europe, Asia, and Africa were Swedish. Following successful endoscopic hemostasis, patients were randomized to 72 hours intravenous esomeprazole or placebo with subsequent oral esomeprazole 40 mg for 27 days. Rebleeding was the primary variable and occurred in 7.2% and 12.9% in the esomeprazole and placebo group, respectively.

**RESULTS:** Data was collected from all 60 patients in the six KPP reporting clinics. Information structure and level of detail varied considerably between clinics, why only total costs are reported. Six patients (10%) were defined as rebleeders, and accounted for 20% of the total costs for all patients. The mean total cost/patient was SEK 39,882 (median 29,082, range: 10,377–263,520) for all patients without rebleeding and SEK 88,928 (median 82,273, range: 52,464–160,090) for all patients with rebleeding (±1 sepsis) per patient without rebleeding varied between clinics from SEK 14,791 to 45,636. CONCLUSIONS: Hospital costs for patients with PUB vary considerably. The cost of patients with rebleeding was more than double that of patients without rebleeding, and in all the 10% of patients who rebleed accounted for 20% of the total hospital costs. In conclusion, a treatment which successfully prevents rebleeding is important not only from a clinical perspective, but also from a cost point of view to reduce hospital costs.

PGI10 MODELLING THE IMPACT OF TREATMENT WITH ENTECAVIR ON HEALTH CARE COSTS OF CHRONIC HEPATITIS B IN FRANCE

**OBJECTIVES:** Chronic hepatitis B (CHB) treatment necessity, according to European guidelines, to use potent antiviral agents with optimal resistance profiles. Increased health care financial burden means physicians, payers and decision makers need to evaluate CHB treatment cost-effectiveness. This model aims to estimate the medical cost savings of treating nucleoside-naïve CHB patients with a potent antiviral agent, from a French payer’s perspective. METHODS: CHB was simulated using a disease-state transition model with states defined as mild fibrosis (ISAK F0/F1), significant fibrosis (F2–F4), advanced fibrosis/cirrhosis (≥F4) and complicated states (decompensated cirrhosis (DC), hepatocellular carcinoma (HCC), liver transplant and death) based on available clinical data. The model assumed a 5-year entecavir treatment and 30-year follow-up and was based on available clinical data. The transition probabilities between states increased with detectable viral load levels and varied by HBAg status. Direct medical costs included CHB and liver complications management. The primary model output is the estimated cost avoided per patient per day of treatment, compared to no treatment in nucleoside-naïve CHB patients. RESULTS: Progression to HCC, liver transplant or death was estimated at 76% for untreated patients compared to 31% for entecavir patients, while the progression to DC, HCC, liver transplant or post-liver transplant resulted in annual costs/patient of 69,718 [95% confidence interval (CI): 8,266, 11,175], 63,066 [4,306, 5,826], 87,105 [74,039, 100,171] and 19,421 [16,508, 22,335], for 2008, respectively. Cost of not treating CHB patients was estimated at €164/day (average over patient lifetime). Entecavir treatment translated into an average cost saving of 3.5 years of entecavir treatment (£95 CI: [−9.6, 4.6]). CONCLUSION: Treatment of CHB using a potent antiviral agent with high genetic barrier to resistance, such as entecavir, is cost-effective as associated with improved clinical outcomes and lower health care costs compared with no treatment.

PGI11 RISK FACTORS AND COSTS ASSOCIATED TO NSAIDS THERAPIES IN ITALY: AN ADMINISTRATIVE DATABASE ANALYSIS

**OBJECTIVES:** Descriptive treatment patterns of NSAIDs, risk factors for gastrointestinal injuries and associated costs. METHODS: Prescriptions of reimbursed NSAIDs in 2007 were selected from ARNO database and analyzed for 12 months in 23 Italian Local Health Units. Intensity of NSAID use and co-medications were analyzed. Cluster analysis and risk stratification were performed to assess the influence of risk factor in NSAID prescriptions and gastroprotective (GP) co-medications. Risk factor analysis was based on prescriptive limiting AIFA (Agenzia Italiana del Farmaco) note 1 for GP: presence of chronic NSAID treatment, age ≥60 years, concomitant antithrombotics, corticosteroids and/or previous gastric events. RESULTS: Among 1,028,100 new NSAIDS recipients (76% of overall treated) 31% received nimesulide, 33% diclofenac, 20% ketoprofen, 13% ibuprofen, 12% COX2 and 10% paracetamol. NSAID prevalence appeared increased with age, whereas decreased in >80 years except for ibuprofen. Fifty-eight percent of patients <60 yo received <80 posolog units/year. Meanwhile, 62% of patients ≥60 yo received >80 posolog units/year. Patients on ibuprofen + COX2 seemed to have more risk factors than at least 2 risk factors in combination with AIFA prescribing note 1 in >33% of patients treated with COX2I (ibuprofen) in comparison with <30% for those treated with the other NSAIDS (P < 0.001). Moreover, ibuprofen, COX2I and diclofenac showed statistically significant higher frequency in the GP co-medication group, (6% compared to other NSAIDS, <1% COX2I). Drug expenditure varied among treatments. Nimesulide and COX2I were associated with the highest NSAID + GP total costs/year, respectively 167 and 212 euros. Despite the high frequency of GP co-medications with ibuprofen and diclofenac, lower expenditures were observed, 138 and 118 euros, respectively. CONCLUSIONS: This analysis showed that cost for gastroprotective co-medications were higher than the cost of NSAIDS alone. However, NSAIDS + GP expenditure differed among NSAID treatment groups.

PGI12 ECONOMIC CONSEQUENCES OF POORLY CONTROLLED PATIENTS WITH GASTROESOPHAGEAL REFUX DISEASE IN GERMANY, ITALY AND SPAIN

**OBJECTIVES:** The aim of this study was to estimate the implications of poorly controlled GERD for patients and the economic implications for health care providers and employers in Germany, Italy and Spain. METHODS: Based on published prevalence and incidence for GERD and its implications and cost data, the number of patients with poorly treated GERD and their implications, as well as the economic consequences for health services and employers were calculated for each country. RESULTS: The amount of patients with poorly treated GERD that have severe oesophagitis are estimated to be 740,364 in Germany, 245,559 in Italy and 225,054 in Spain per year. The number of patients with Barrett's oesophagus are estimated to be 29,678 in Spain, 19,327 in Germany and 10,079 in Italy. The number of patients with complicated oesophagitis are around 35 patients in Germany, 15 patients in Italy, and 16 patients in Italy. Costs for poorly treated GERD patients for the health services were estimated to be €18 million for Spain, €12 million for Germany and €7 million for Italy. Absentism and presenteeism costs due to poorly controlled GERD for employers were almost none. CONCLUSIONS: Costs for complications in patients with poorly controlled GERD added costs for health care systems for all three countries but almost no extra costs were found for employers.