beneficiaries who were enrolled in an MA-PD or a drug plan with drug deductibles, tiered copayments, or mailorder services in the plan benefit design were more likely to experience CRR.

**Abstracts**

**PHM4**

**HEALTH CARE UTILIZATION AND COSTS AMONGST WOMEN WITH FEMALE SEXUAL DYSFUNCTION (FSD) AND HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD)**

**PERSPECTIVE:** For Health Care Utilization Study powered by Thomson Reuters, Philadelphia, PA, USA; Boehringer Ingelheim Ltd, Ridgefield, CT, USA; Boehringer Ingelheim Pharmaceuticals, Inc, Ridgefield, CT, USA

**OBJECTIVES:** The health care utilization and costs among commercially insured women with a diagnosis of Female Sexual Dysfunction (FSD) and Hypoactive Sexual Desire Disorder (HSDD) in the United States. **METHODS:** The Thomson Reuters Marketscan® Database was used to identify women aged 18–64 with an ICD-9-CM coded diagnosis of FSD, including a subset with HSDD from January 1, 1998–September 30, 2008. All women with no diagnosis of any sexual dysfunction were matched 3:1 to cases based on age, health plan and enrollment period. Controls were assigned the index date of their matched case. Health care utilization and costs were examined in the year prior (“pre-period”) and to following index (“post-period”). **RESULTS:** A total of 46,811 women were coded as FSD (59% as HSDD) and matched to 14,493 controls. The FSD group had more outpatient visits and services in both the pre- (22.7 vs. 16.2, p < 0.001) and post- (25.4 vs. 17.7, p < 0.001) periods compared with their matched controls. They also consistently filled more prescriptions in the pre- (14.5 vs. 11.5, p < 0.001) and post- (16.2 vs. 7.2, p < 0.001) periods. More similar patterns of increased health care utilization were also seen in the post-period for both FSD and HSDD patients ($13,109 and $9,167 respectively). The most significant drivers of health care costs for both groups were outpatient medical services (including professional visits, outpatient surgeries, and laboratory expenditures) and total prescription medication costs. **CONCLUSIONS:** Women diagnosed with FSD and HSDD use significantly more health care services than women without diagnosed sexual dysfunction. The resulting higher costs are driven by a greater use of outpatient services and prescription medications.

**PHM5**

**CARES: THE CANADIAN REGISTRY OF SYNAGYS® SUMMARY OF 2006–2008 RSV SEASONS**

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**OBJECTIVES:** To understand current management (utilization, compliance) with palivizumab prophylaxis of children at high-risk of RSV infection in Canada. **METHODS:** A prospective, observational, registry of infants at high risk for RSV who received at least one dose of palivizumab during the 2006–2008 RSV seasons from 24 sites. Neonatal and demographic data were collected upon enrollment. Data on palivizumab utilization and compliance, including outcomes related to a respiratory infection were collected monthly until the full course of palivizumab was completed or at the end of the relevant RSV season. **RESULTS:** A total of 2910 infants were enrolled, age two days to 47 months (mean = 5.5 months). In total, 54.4% were male, 62.2% Caucasian, average gestational age (GA) was 32.0 ± 6.8 weeks completed. 2079 (71.4%) infants received palivizumab because they were premature only (i.e. ≤35 completed weeks GA), 255 (8.8%) required oxygen, 288 (9.9%) had congenital heart disease and 288 (9.9%) were prophylaxed for other risk factors such as CNS disorders, airway anomalies and cystic fibrosis. Compliance was high; 77.8% received at least four injections of palivizumab between September and June each season. Overall, 12, 973 doses were given. No directly related serious adverse events were identified. A total of 159 infants had 194 hospitalizations for respiratory tract infections (hospitalization rate 5.5%) and rates were highest in those with chronic lung disease (9.8%, p = 0.006). The RSV positive hospitalization rate was only 0.96%. **CONCLUSIONS:** The RSV hospitalization rate observed in the 2006–2008 RSV seasons was lower than that found in several published reports (range 1.3–5.3%). The rates of RSV hospitalization may be decreasing for various reasons such as high compliance with palivizumab prophylaxis, variability in RSV epidemiology, hospital admission criteria and preventative education.

**Mental Health – Clinical Outcomes Studies**

**PMH6**

**DEPRESSION: ETHNIC DIFFERENCES IN PREVALENCE, DIAGNOSIS, AND SYMPTOMS**

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**OBJECTIVES:** To assess ethnic differences in the prevalence, physician diagnosis and symptomatology of depression. **METHODS:** Data were taken from the 2008 US National Health and Wellness Survey (NHWS), a self-reported, Internet-based study of the disease status, attitudes, habits, and outcomes of adults age 18+. Ethnic groups included whites, blacks, Hispanics and Asians. Respondents self-represented experiencing depression, depression diagnosed by a physician, and experiencing the following in the previous month: bothered by feeling down, depressed, or hopeless; bothered by having little interest or pleasure in doing things. Prevalence was calculated using frequency weights based on age, gender and race. Chi-square analyses were conducted to assess statistically significant differences. **RESULTS:** Of the 61,016 respondents, 12.2% (Projected 33.8M; 25%) reported experiencing depression within the previous year. There were significant (p < 0.05) variations across ethnic groups: White = 39.5M, 25.8%; Black = 4.9M, 19.8%; Hispanic = 8.1M, 27.6%; Asian = 1.3M, 16.1%. Among those who report experiencing depression, whites were more likely to be diagnosed (77.0%) compared with 60.8% of blacks, 62.8% of Hispanics, and only 48.4% of Asians, who were least likely to be diagnosed. Among those who did not self-report experiencing depression, 12.1% of whites, 12.8% of blacks, 13.1% of Hispanics and 11.4% of Asians experienced depression symptom and 9.5% of whites, 11.9% of blacks, 12.3% of Hispanics, and 12.2% of Asians experienced both depression symptoms (p < 0.05). **CONCLUSIONS:** While there is significant ethnic variation in prevalence of self-reported depression, there is even greater ethnic variation in diagnosis among patients experiencing depression. Also, recognition of symp-