Costs were calculated on the actual resources used by each patient and assigned to the treatment group to which the patient was randomized. Direct medical resource use data was costed over six months post transplantation. A local health economist collected cost information from published sources and personal interviews with clinicians. Costs were collected on study drug, concomitant medication, hospitalization, dialysis, and rejection episodes. To explore the impact of any variability of costs, a one-way sensitivity analysis was conducted. RESULTS: Six months after transplantation, patient survival was 99.3% (Tac) and 98.5% (CyA), p = 0.366; graft survival was 94.6% (Tac) and 91.9% (CyA), p = 0.139. The incidence of acute graft rejection was 32.5% (Tac) and 51.3% (CyA), p < 0.0001. Cost-minimization analysis revealed savings for tacrolimus (per patient) of Euro 583–1874 for surviving patients, and Euro 781–2305 for patients with functioning grafts. Tacrolimus was cost-effective for patients with rejection-free grafts; savings per patient were Euro 4627–9919. The tacrolimus group consistently had lower total costs than the cyclosporin group. The cost advantages for tacrolimus were a result of lower overall hospitalization costs and lower incidences of dialysis and graft rejection. CONCLUSION: A sensitivity analysis regarding the main cost drivers (hospitalization, study drug, and concomitant medication) generally confirmed the robustness of this finding across all three countries.

**PRK8**

COSTS AND CLINICAL CONSEQUENCES OF ALFUZOSIN AND DOXAZOSIN IN BENIGN PROSTATIC HYPERPLASIA IN UKRAINE

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OBJECTIVE: Randomized controlled clinical trials have demonstrated, that alfuzosin (dalfaz R) is comparable to doxazosin (cardura) in benign prostatic hyperplasia. We compare the costs and clinical consequences of alfuzosin vs doxazosin from the perspective of public health care in Ukraine. Both drugs provide long-lasting relief of symptoms. METHODS: We compared the rates of PSA assay, of prostate volume, of while urinary flow (Qmax). Patients filled in both the generic IPSS. To calculate the drug-acquisition costs. RESULTS: A total of 106 patients (54 alfuzosin, 52 doxazosin) were treated in 6 months. The mean age of patients was 63.7 years. Relief was seen as early as one week after the initiation of therapy. We compared the rates at 1, 3, and 6 months; the prostate volume decreased by 18% and 19% in the doxazosin and alfuzosin groups, respectively, while urinary flow (Qmax) increased by 28 to 29%. The mean percent change in IPSS was 39.8% (p < 0.05). Overall symptoms improved in two groups. The direct costs of alfuzosin were 910.0 UAH vs doxazosin 714.1 (1USD = 5.3 UAH) per one patient. The total cost of 100 patients treated with doxazosin were decrease by 27.4% vs alfuzosin. CONCLUSIONS: There was no difference in the clinical consequences of doxazosin vs alfuzosin treatment. Our study showed that the treatment with doxazosin may offer economic advantages over alfuzosin, the results may provide a basis for creation of formulary system in Ukraine.

**PRK9**

COST-EFFECTIVENESS OF TAMULOSIN, DOXAZOSIN AND TERAZOSIN IN THE TREATMENT OF BENIGN PROSTATIC HYPERPLASIA

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OBJECTIVE: To evaluate the cost-effectiveness of tamsulosin, doxazosin or terazosin as initial treatments for moderate benign prostatic hyperplasia (BPH). METHODS: A decision analytic model is used to project the costs and effectiveness of treatment at 6-month intervals over three years following initiation of therapy with tamsulosin, doxazosin or terazosin. Patients initially treated with doxazosin or terazosin who discontinue due to hypotensive events are switched to tamsulosin. Finasteride is added in the event of treatment failure not related to adverse events. Medical treatment failures transition to transurethral resection of the prostate (TURP) and, if needed, a second TURP. Values for treatment failure rates and clinical event cost parameters are derived from the literature. Only direct medical costs are included and are discounted by 3% per year. Effectiveness is measured as successful medical treatment (without TURP) over three years. RESULTS: In the reference case, discounted BPH-related total direct medical costs over 3 years are $3715, $3756, and $3992 for generic terazosin, generic doxazosin, and tamsulosin, respectively. Estimated medical treatment success rates at 3 years are 72.41% for tamsulosin, 69.62% for terazosin and 69.28% for doxazosin. The incremental cost for tamsulosin vs. terazosin is $278, which yields an incremental cost-effectiveness ratio of $9964 per success. Decision model results are sensitive to parameter values for treatment efficacy, drug costs, discontinuation rates, and dosing frequency. CONCLUSION: As an initial medical therapy for moderate BPH, tamsulosin is more effective than generic terazosin or doxazosin, with an incremental cost of about $93 per year or about $7.75 per month. From a payer’s perspective, with differential generic/brand patient co-pays of $8/month or more, tamsulosin is cost saving.

**PRK10**

COST-MINIMISATION ANALYSIS AND ACCEPTANCE OF SELF-INJECTING SUBCUTANEOUSLY R-HUEPO WITH RECO- PEN® FOR MANAGEMENT OF ANAEMIA IN A POPULATION OF FRENCH ADULT PATIENTS ON DIALYSIS

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OBJECTIVE: To compare the costs and clinical consequences of alfuzosin vs doxazosin treatment. Our study showed that the treatment with doxazosin may offer economic advantages over alfuzosin, the results may provide a basis for creation of formulary system in Ukraine.
OBJECTIVES: to estimate economic consequences and patients acceptance of a program proposing a switch toward self-injection of a recombinant Human erythropoietin (r-HuEPO) NeoRecormon with Reco-Pen® in a population of adult patients on dialysis. METHODS: A cost-minimisation study was performed in a societal perspective to assess the economic consequences of the program proposing Reco-Pen®, to facilitate self-injection in patients requiring a treatment with r-HuEPO. A random national sample of French patients in maintenance dialysis or in pre-dialysis were selected. A nurse was dedicated in each centre to educate and assist patients during the study period. Direct costs of injecting r-HuEPO before and after the program were estimated including purchase of the device and erythropoietin, time spent by nurses for injection and education of patients or caregivers. Data were collected on all relevant items retrospectively and prospectively during a 2-month follow up period. An acceptance study was conducted including self-evaluation of pain during injection, easiness of use and satisfaction. RESULTS: One hundred twenty-four patients in 42 centres were enrolled in Fall 2001. Eighty-seven percent of patients were in maintenance therapy and the rest in correction phase. The satisfaction scores were positive in 80% of patients in terms of improved autonomy and comfort and 93% declared themselves ready to go on using the pen. The self-injection rates grew from 21% to 53%. The switch to Reco-Pen® of 100 patient x year was associated with an economic gain of €22,449 broken down as following: €18,725 corresponding to the benefit on r-HuEPO purchase cost, €3,500 corresponding to the costs avoided by reducing the number of injections performed by office-based nurses, and €224 due to the reduction of total time spent by nurses in the centres. CONCLUSIONS: The short-term acceptance of self-injection with Reco-Pen® in a program proposing the assistance of dedicated nurses is high and associated with an overall economic benefit.

THE ECONOMICS OF PHOSPHATE BINDERS IN RENAL DIALYSIS: A TWO-STAGE STRATEGY FOR MANAGING HYPERPHOSPHATEMIA

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OBJECTIVES: Because the outcomes and cost of caring for patients with ESRD are of major concern, we analyzed claims data of patients receiving exclusively either Calcium Acetate (CA) or Sevelamer HCl (SHCl). METHODS: From the California Medicaid (Medi-Cal) program we compared 1401 ESRD patients who were prescribed CA and 192 who were prescribed SHCl during a 2-year period. RESULTS: For this population, the median daily dose and cost were 4447mg ($0.55) for CA and 4030mg for SHCl ($2.88), a significant difference by multivariate regression analysis that controlled for patient demographics, co-morbidities, hospital admissions, and time on binder. Not unexpectedly, comorbid conditions such as COPD, diabetes, heart disease, and hypertension were significantly associated with costs and number of hospital admissions. However, in patients who had been prescribed binder for at least 12 months, there was no statistically significant association between choice of binder, cardiovascular and other co-morbidities, downstream medical resource utilization or costs. Moreover, there was no difference between the binders with regard to time to first hospitalization as well as the number of hospital admissions. For a hypothetical cohort of 1000 ESRD patients treated over a 2-year period, the use of CA as a first-line agent, switching to SHCl only patients who become hypercalcemic, would save almost $1.4 million with no change in patient morbidity. Savings would be substantially greater if the same approach is followed for the entire US dialysis population. CONCLUSION: The choice of phosphate binder does not have a significant impact on the medical costs (except cost of phosphate binder), or number of hospitalizations, or time to hospitalization during follow-up for patients with ESRD. However, implementing a 2-stage strategy for phosphate binders has the potential to significantly reduce the cost of managing hyperphosphatemia in ESRD patients without having any detrimental effects on this population.

URINARY & KIDNEY DISEASES/DISORDERS—Quality of Life/Preference Based Outcomes

COMPARING SENSITIVITY TO CHANGE BETWEEN I-QOL AND SF-36 IN A POPULATION WITH URINARY INCONTINENCE

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OBJECTIVE: To report comparisons of the sensitivity to change between a condition-specific quality-of-life measure (I-QOL, specific to urinary incontinence) and a generic health status measure (SF-36). METHODS: Incontinent female patients completed the I-QOL and the SF-36 measures at screening, pre-treatment, and four subsequent follow-up visits during participation in a multicenter, double-blind, placebo-controlled randomized trial to assess the efficacy of duloxetine in the treatment of urinary incontinence. Sensitivity analyses were conducted using baseline and week 6 data (or last observation carried forward if participant was an early dropout). Only responders to stress pad test (25% decrease), incontinent episodes (25% decrease) and perceived global impression (a little better) were evaluated. I-QOL scores and SF-36 scores are both transformed onto a 0 – 100-point scale. RESULTS: For individuals having a decrease in pad weight of at least 25%, change scores of the SF-36 ranged from 0 (General Health) to 4 points (Bodily Pain, Physical Functioning, Role Emotional, and...