direct costs (versus 0) and the probability that patients with positive costs spent more than €4000 (versus less than €4000). RESULTS: Out of the 3494 questionnaires mailed 1189 (34.0%) were returned and fully completed. The mean age of respondents was 53.1 years (SD 8.6); 83.4% were women and the mean RA duration was 14.7 years (SD 10.3). Overall, 49.9% of the survey, 45.9% declared being on RA work disability perceiving pension invalidity. A total of 45.3% of employed patients had at least one sick leave over the past 6 months, with on average a cumulative duration of 11.6 days over the year. The annual average estimated indirect cost was €3210 (74.4% RA-related work disability and 25.6% due to RA sick leaves). The three main risk factors associated with higher costs were: failure of at least one biotherapy (Odds Ratio – OR = 4.8), RA poor functional status (severe HAQ versus mild HAQ, OR = 3.8) and on-going treatment (disease-modifying antirheumatic drugs vs. biologic, OR = 3.5). A high level of education is protective (OR = 0.6).

CONCLUSIONS: Pursuing preservation of functional status by treating patients earlier before irreversible joint damages could both improve patients’ work conditions and lead to potential savings for the Health Insurance.

PM064

ANALYSIS OF HOSPITAL EVENTS MEANING IATROGENICITY, ANHemie

Vandenhock A1, Kosa M1, Dazearque R1, Larriale L1, Dury G1

1HEV Health Evaluation, Lyon, France, 2PFIZER FRANCE, Paris, France, 3PFIZER, Walton Oaks, UK, 4Université Caude Bernard, Lyon, France

OBJECTIVES: Rituximab and infliximab are biologic disease modifying anti-rheumatic drugs (DMARDs) used to treat rheumatoid arthritis (RA). Rituximab is re-administered due to symptoms symptoms return, but infliximab has fixed dosing intervals. This 3 centre observational study was to determine the secondary care resource and patient time implications of this difference. METHODS: Medical records of 44 patients with RA, treated with rituximab (n = 26) or at least 2 courses of rituximab (n = 18) were reviewed retrospectively to determine mean time between 1st rituximab course and start of the 2nd, and numbers of visits and investigations for both drugs. Staff and patient time required for drug administration was measured prospectively by direct observation of 25 patients receiving infliximab (n = 13) or rituximab (n = 12). RESULTS: Mean time between 1st and 2nd courses was 43 weeks (range 15-84). During this time a mean of 6.9 (range 4-18) infliximab infusions was administered. Rituximab-treated patients required 2 visits for drug administration during this time, vs. infliximab 6.9 visits. Each visit required a mean of 87.2 minutes of staff time for rituximab patients vs. 46.0 minutes for infliximab. Total staff time per patient over 43 weeks was 2.9 hours for rituximab vs. 5.3 hours for infliximab. Mean total patient time in the unit per 43 weeks was 14.1 hours for rituximab vs. 25.3 hours for infliximab. CONCLUSIONS: Although rituximab requires almost twice as much staff time per visit for its administration as infliximab, it is administered less often so staff time required over a whole course is less for rituximab than infliximab. An even greater difference was seen for patient time spent on the unit for drug administration. This study demonstrates benefits from rituximab in terms of patient convenience and staff efficiency, which can inform NHS planning of service delivery and quality standards for patients with RA.