OBJECTIVES: Major depressive disorder affects approximately 10-15% of the popula-
tion and is associated with significant morbidity and mortality. It is one of the leading
causes of disability in young adults. A large proportion of the burden can be
attributed to treatment-resistant depression (TRD). To understand the prevalence
and disease burden of TRD in Western European countries, the US and Canada, a
systematic literature review was performed. To compare heterogeneity among the
reporting countries and the CRD database were used to retrieve TRD publications in English language
from January 2003-October 2013. In total, 636 abstracts were identified. Predefined
selection criteria for this study are: patient population (age ≥18 years, US, Canada,
Germany, Italy, France, Spain or UK; TRD defined as one treatment failure and
high symptom severity e. g. MADRS ≥31, or an inadequate response to ≥ two
antidepressants) and outcomes of interest were applied. RESULTS: Only seven stud-
ies included prevalence and/or disease burden data. Five studies provided previ-
ous estimates which adhered to the strict TRD definition used for this review.
Study design and definition of the patient population were critical in determining
the prevalence rates, with the lowest rates in US administrative databases (11-15%),
higher rates in commercial health insurance databases (29-31%) and the highest
rates in a European multicenter study (51-56%). The database studies mainly
included employed patients thereby likely underestimating the prevalence, whereas
the previous estimates likely overestimated the prevalence due to a less stringent
TRD definition. Inconsistent data were reported regarding treatment outcomes, comor-
bidities, hospitalization and work productivity. There was no information on other
outcomes such as health-related quality of life or functioning. CONCLUSIONS: No consistent data were found in the literature from January 2003-October 2013 regarding
the epidemiology and disease burden of TRD. To determine the prevalence and
disease burden for TRD, further studies are needed.

PMH15 PREVALENCE OF METABOLIC SYNDROME IN PATIENTS WITH SCHIZOPHRENIA ACCORDING TO THE PRESENCE OR ABSENCE OF NEGATIVE SYMPTOMS
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OBJECTIVES: The aim of this study was to estimate the prevalence of metabolic syn-
drome (MS) in patients with schizophrenia according to the presence or absence of
negative symptoms. METHODS: A retrospective, cohort study was conducted using
electronic medical records from the health provider BSA (Badalona, Spain). All adult
patients with schizophrenia in Brazil experienced 263,037 episodes of relapse that
were included in the analysis. During the first year after the initial filled prescription were identified. The
end of a treatment episode was defined as a period of 60 days with no filled BUP/
episodes in the year following the end of the first episode. Health care resource utilization and related costs during the
first year were compared between patients with and without TRD. RESULTS: 2,223 patients were included in the analysis. During the first year, 86% of patients
had only one treatment episode, 13% had two and 1% had three. Compared to patients who remained in treatment continuously over 12 months, the multiple treatment episode group had lower medication costs (~$2,877) but higher psychi-
atriac inpatient costs (~$720), non-psychiatric inpatient costs (~$2100) and emergency
room costs (~$300) over 12 months. Total health care costs over 12 months
were significantly higher from the perspective of the Brazilian private health care system compared to R-LA. In addition, PP offers advantages that can have additional value for public and private payers alike such as a monthly injection and no need for
cold chain. PP can therefore be considered a cost-saving therapeutic option for schizophrenia compared to R-LA.

Mental Health – Cost Studies

PMH16 THE POTENTIAL BENEFITS OF LONG-ACTING ATYPICAL ANTI-Psychotics THERAPY TO IMPROVE RELAPSE IN BIPOLAR I DISORDER
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OBJECTIVES: To quantify the economic burden of schizophrenia relapse in Brazil,
and to estimate the impact of atypical Long-Acting Injectables (LAIs) on relapse.
METHODS: Administrative health service data from a Brazilian public system
database (DATASUS) were used to estimate the number of relapse patients and related
resource utilisation. Corresponding data for private system patients were estimated
from the Brazilian Private Health Care System Base (2011/2012) was used to define a cohort of Non-TRD and TRD claimants. TRD
was defined as those on their third antidepressant monotherapy, or combination antidepressant therapy, or antidepressant associated with augmentation, thyroid hormone or an antipsychotic medication. The cost of prescription medica-
tion utilization, short-term disability (STD), and long-term disability (LTD) benefits for employees was calculated (2011 and 2012 SCAN) for both Non-TRD and TRD groups. Descriptive statistics were used to characterize the cohort of claimants
and employees, as well as resources and costs for employees. RESULTS: There were
55,324 and 61,028 employee claimants in 2011 and 2012, respectively. 717 (1.3%)
and 751 (1.2%) were identified respectively as having Non-TRD and TRD
claimants in 2011 and 2012, respectively. In 2011, the medication costs for
treating depression was $774 per TRD employee claimant compared to $303 per Non-TRD employee. Standard costs were $6,263 for TRD (n=79) and $5,855 for Non-TRD (n=276). LTD costs were $13,598 for TRD (n=80) and $12,272 for Non-TRD (n=119). In 2012, the medication costs for treating depression per TRD employee claimant was $794 compared to $293 for Non-TRD claimants. STD costs were $7,832 for TRD (n=48) and $7,001 for Non-TRD (n=43). LTD costs for TRD (n=89) and $12,901 for Non-TRD (n=121). CONCLUSIONS: Employees identified with TRD had higher medication, STD and LTD costs than those with Non-TRD. Limitations include lack of diagnostic information for claimants and small sample sizes for STD and LTD subgroups.