lated quality of life (HQL). **METHODS:** The SF-36 Health Survey (SF-36) was self-administered by 632 participants of a double-blinded, randomized controlled clinical trial of three treatments for RA. The burden of early RA (≤3 years) on HQL was estimated by comparing SF-36 scale scores with general US population norms and benchmarks for 6 chronic conditions: diabetes, depression, congestive heart failure (CHF), asthma, chronic obstructive pulmonary disease (COPD) and osteoarthritis (OA). General US population norms and disease specific benchmarks were adjusted to the age, gender and race of the early RA patients. **RESULTS:** SF-36 scale scores were significantly ($P < 0.0001$) lower for early RA patients, relative to age, gender and race adjusted general US population norms. Scales measuring physical health status were most affected by early RA compared to scales measuring mental health status. Scale scores of early RA patients were as low or lower than those observed for patients with CHF, diabetes, OA, COPD, and asthma. Early RA scores on mental health were better than those observed for patients with depression. **CONCLUSIONS:** HQL measures are helpful in quantifying the impact of early RA on patient functioning and well being. Early RA patients report substantially diminished functioning and well being, compared to the general US population. Patients with early RA reported health status and functioning at least as low as patients commonly considered to have more debilitating diseases.

PAR2

PHARMACOECONOMICAL ANALYSIS OF NON-STEROID ANTI-INFLAMMATORY DRUGS IN RHEUMATOLOGY

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Non-steroid anti-inflammatory drugs (NSAID) are widely used in Russia in all fields of medicine. At the same time they produce serious side effects such as gastric or duodenal ulcer and gastrointestinal bleeding, that may influence the cost of illness. **OBJECTIVE:** The study purpose was to conduct an economic analysis of two drug regimens for rheumatoid arthritis and osteoarthritis: regimen A (meloxicam 7.5 mg/day) regimen B (diclofenac 100 mg/day). **METHODS:** Decision-analysis was performed. Clinical efficacy and probability of side effects was taken from multicenter clinical trials. Costs of baseline treatment and cost of treatment for side effects were analyzed. **RESULTS:** Clinical efficacy in both regimens was equal. Probability of side effects was 1.5 times higher in diclofenac than meloxicam (0.031 vs 0.019) according to the trials. Cost of standard treatment for side effects was $6.80 US for minor symptoms, $12.20 US for ulcer at out-patient department, and $188.04 US for ulcer at hospital. Such low costs are explained with low levels of prices for medical services in the system of medical insurance. Cost of period of treatment including treatment for side effects was $20.09 US for diclofenac and $15.42 US for meloxicam. **CONCLUSIONS:** Treatment with meloxicam was cheaper than with diclofenac, but the difference was mostly explained by the price of drugs, because prices for medical services are very low in Russia. Presently in this country drug prices are most important, as they are determined by market forces while prices for medical services are regulated by the state and are low because of limited resources.

PAR3

REDUCED UTILIZATION OF ANTIULCERANT DRUGS WITH CELECOXIB: FINDINGS OF THE PAINLESS TRIAL

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The introduction of celecoxib has led to the assumption that utilization of antiulcerants may be reduced. **OBJECTIVE:** The purpose of this clinical practice study was to assess the cost benefit of switching arthritis patients from non-steroidal anti-inflammatory drugs (NSAIDs) and concomitant antiulcerants to celecoxib. **METHODS:** 190 male and female (67%) patients with osteoarthritis (157) or rheumatoid arthritis (33) who were either maintained on an NSAID or who could not tolerate prescription NSAIDs at the baseline visit, were evaluated in this prospective, open-label, nonrandomized study. Patients were switched or started on celecoxib and counseled by the prescribing physician to discontinue any antiulcerants and limit use of OTC NSAIDs. Patients returned for 2 monthly follow-up visits for further assessments and tabulation of concomitant drug use. **RESULTS:** Of the 110 patients treated with traditional NSAIDs and/or disease modifying agents, 25% were maintained on ibuprofen, 19% on aspirin, and 13% were maintained on nabumetone or diclofenac+misoprostol. 82 patients were taking a proton pump inhibitor (omeprazole [30] or lansoprazole [14]), histamine antagonist (ranitidine [12] or famotidine [11]), or misoprostol (9). Over a 3 month follow-up period, 71 (87%) of these patients had discontinued the antiulcerants at time of switching to celecoxib. Based upon AWP pricing, the switch to celecoxib with discontinuation in antiulcerants resulted in an average daily savings of $2.65 US per patient. **CONCLUSION:** Appropriate switching of arthritic patients from their traditional NSAID and antiulcerant to celecoxib results in a significant cost savings to the patient and managed care organization.