p < 0.05). The average 12-month costs per MDD patient were substantially higher for severe vs. mild (mental health services: $718 vs. $416; general medical services: $133 vs. $57; antidepressant usage $275 vs. $89). **CONCLUSIONS:** There was a significant association between depression severity and treatment usage and costs, as well as between treatment adequacy and severity.

PMH30

ANTIDEPRESSANT THERAPY DURING PREGNANCY: AN INSIGHT ON ITS POTENTIAL HEALTH CARE COSTS

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OBJECTIVES: To compare the direct health care costs, during and after pregnancy, between women who continue their antidepressant therapy during the whole gestational period and those who discontinue their treatment during the first trimester. **METHODS:** Data from a 'Medications and Pregnancy' registry were used. Eligible women were 1) aged 15—45, 2) insured by the Quebec drug plan for ≥12 months prior to, during pregnancy, and ≥3 months after pregnancy, 3) had ≥1 diagnoses of psychiatric disorders before pregnancy, 4) used antidepressants for ≥30 days in the year before pregnancy, and 5) had delivered. Women who continued their antidepressant therapy throughout pregnancy (Group 1) were compared to those who discontinued during the first trimester (Group 2). Health care costs, expressed as mean total costs and cost ratios were determined during and after pregnancy. **RESULTS:** In total, 2822 women met inclusion criteria. Of these, 501 (17.8%) were in Group 1, and 676 (23.4%) in Group 2. The median number of days of antidepressant use before pregnancy was higher in Group 1 (260 days vs. 144 days, p < .01); the proportion of women visiting a psychiatrist was also higher in Group 1 (33.7% vs. 26.8%, p < .01). The mean total cost during pregnancy in Groups 1 and 2 were $2981.5 vs. $1842.9 (p < .01), and after pregnancy $1761.2 vs. $1024.9 (p < .01). When prescription costs were excluded, these differences in costs were no longer significant. **CONCLUSIONS:** Women who use antidepressants during pregnancy are likely to have disorders of greater severity compared to those who discontinue during the first trimester. They incur significantly greater health care costs. However, this increased cost is attributable to higher prescription costs.

PMH31

A GPRD-BASED COMPARISON OF SECOND-LINE ANTIDEPRESSANT THERAPY WITH ESCITALOPRAM AND VENLAFAXINE

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OBJECTIVES: British guidelines recommend escitalopram and venlafaxine as second-line treatments in major depressive disorder (MDD). Clinical trials demonstrated similar efficacy and better tolerability of escitalopram vs. venlafaxine. To assess how these results translate into real-life, this study compared second-line treatment strategies with escitalopram or venlafaxine after failure of first-line generic SSRI, based on drug utilisation and economic outcomes in patients with MDD in the UK. **METHODS:** This cohort study using the General Practitioners Research Database (GPRD) included adults with a diagnosis of MDD, who had switched from a first-line generic SSRI to escitalopram or venlafaxine between January 1, 2003 and June 30, 2005. A 6-month drug utilisation outcomes were dose-adjustments, mean treatment duration (TD), and successful treatment stop (no subsequent need for treatment) after switch. 6-month economic outcomes were health care resource use and total health care costs, calculated by adding up unit costs applied to resources. Appropriate multivariate models were built, using propensity scoring to control on baseline characteristics. **RESULTS:** A total of 535 patients were switched to escitalopram, 1284 to venlafaxine. In the escitalopram cohort compared with the venlafaxine cohort, there were fewer males (32% vs. 38%, p = 0.02) and patients had a shorter median time to switch (50 vs. 59 days, p = 0.005). Fewer drug adjustments were needed with escitalopram (27% vs. 44%, p < 0.001); consequently, a shorter second-line treatment duration (106 vs. 123 days, p = 0.003), numerically more successful stops (37% vs. 32%, p = 0.25), and fewer GP visits (12.3 vs 13.4 visits/patient, p = 0.06) were observed in escitalopram-treated patients. 6-month total health care costs were significantly lower with escitalopram (£629 vs £749, p = 0.028), and were similar in both cohorts without treatment costs (£567 vs. £589, p = 0.73). **CONCLUSIONS:** After failure of a first generic SSRI, second-line treatment with escitalopram was associated with easier management, shorter second-line treatment duration and earlier success, with no increase in health care cost, compared with venlafaxine.

PMH32

A GPRD STUDY OF HEALTH CARE COST ASSOCIATED WITH DIFFERENT FIRST-LINE ANTIDEPRESSANT TREATMENTS IN SEVERE DEPRESSION

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OBJECTIVES: In the UK, guidelines recommend generic selective serotonin reuptake inhibitors (SSRIs) as first-line treatment, and more expensive drugs such as escitalopram or venlafaxine as second-line treatment for major depressive disorder (MDD). However, clinical trials have shown that escitalopram is more efficacious than SSRIs and at least as efficacious as venlafaxine with better tolerability in severe MDD. The objective of this study was to compare first-line treatment with generic SSRIs, escitalopram or venlafaxine based on 12-month health care utilization and associated direct costs in patients with severe MDD in the UK. **METHODS:** This cohort study using the General Practitioners Research Database (GPRD) included adults with a diagnosis of MDD classified as severe by published algorithm, and a new prescription of generic SSRI, escitalopram or venlafaxine between 2003 and 2005. Twelve-month resource use was assessed; annual total health care cost was calculated by adding-up unit costs for all health care resources and compared between treatments using a generalized linear model; propensity scoring was used to control for confounders and baseline costs. **RESULTS:** A total of 1947 patients started with a generic SSRI, 323 with escitalopram and 215 with venlafaxine. No difference in baseline characteristics was seen between groups. After treatment start, hospitalizations were less frequent in escitalopram-treated patients vs. SSRIs (0.1 vs. 0.2 hospitalization per patient, p = 0.05) or venlafaxine (0.1 vs 0.3, p < 0.01). Total health care cost for escitalopram was numerically lower than for generic SSRIs (£916 vs £974, p = NS) and significantly lower than for venlafaxine (£916 vs £1367, p < 0.001), also when excluding drug costs (escitalopram vs. SSRIs: £831 vs. £957, p = 0.10; vs. venlafaxine: £831 vs. £1156, p = 0.01). **CONCLUSIONS:** In severe MDD, costs associated with first-line escitalopram were similar to generic SSRIs, but lower than with venlafaxine, independently of drug costs. The main driver was the lower frequency of hospitalization for escitalopram-treated patients.