modifying anti-rheumatic drugs (DMARDs) or to both DMARDs and anti-TNFs received the RA RTX regimen (1g×2). The clinical outcome measure was moderate/good EULAR response at 24 weeks. Responding patients were eligible to re-treatment with RTX upon disease exacerbation after a minimum of 48 weeks. Costs of RTX treatment (drug acquisition & administration) were compared to average costs of the spared anti-TNFs (infliximab, etanercept or adalimumab) that would have been provided otherwise to each patient until RTX re-treatment or end of follow-up (FU). Prices are based on Israeli tariff before VAT.

RESULTS: A total of 108 patients were enrolled. Sixty-seven DMARDs failures (62%), 41 DMARDs and anti-TNF failures (38%). At time of analysis (January 2008), 89 patients completed a minimum of 24 weeks follow-up (FU). Three dropped out in less than 24 weeks. Median FU: 75 weeks. 35/89 patients (39%) received re-treatment with RTX at a median of 63 weeks. A total of 37/89 patients (42%) were (at time of analysis) still on FU with no other treatment (median FU: 93 wks). Average cost in Israel of anti-TNF treatment: NIS1955 (~$24,360)/week Cost of RTX (2g): NIS34,448 (~$4,320). The total saving per patient (up to data cutoff) results in NIS85,258 (~$10,600). Costs of RTX treatment (drug acquisition & administration) were compared to average costs of the spared anti-TNFs (infliximab, etanercept or adalimumab) that would have been provided otherwise to each patient until RTX re-treatment or end of follow-up (FU). Prices are based on Israeli tariff before VAT. The objective of the present study was to assess the use of health care resources, imposing a substantial economic burden to patients, health insurance and to society in a public health care setting.

CONCLUSIONS: From the payer perspective, RTX treatment is a significant cost-saving alternative for patients with RA in the Israeli public health care setting.

COSTS AVOIDED BY DIAGNOSING FIBROMYALGIA IN SPANISH PATIENTS
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OBJECTIVES: To estimate the cost savings in outpatient medical resource use associated with diagnosing fibromyalgia during the four years after fibromyalgia diagnosis. METHODS: A questionnaire was created based on the medical resources use from 2260 patients diagnosed with FM between January 1998 and March 2003 in the General Practice Research Database (FF-GPRD) in United-Kingdom. Local experts were asked to compare their own clinical practice to UK prescriptions and resource use, over a period of four years before diagnosis to four plus years after diagnosis using one year cross-sections. Poisson loglinear regression models, published for the UK, allowed to estimate the medical resources consumed if no diagnosis had been established. The impact of diagnosis was evaluated for each of these medical resources. Costs were calculated by multiplying resource use with corresponding Spanish unit costs (€; 2008; both public health care payer perspective and societal perspective including patient co-payments). RESULTS: This study confirms previously published results obtained for the UK and France: whereas costs gradually increase before diagnosis, a stagnation in costs increase occurs in the year after diagnosis, subsequently followed by a moderate decrease afterwards. The savings made as a result of fibromyalgia diagnosis add up to €421 per patient and per year from the health care system perspective and €432 from a societal point of view. Diagnostic tests, referrals to specialists, GP visits and drugs represent respectively 42%, 29%, 15% and 14% of these savings, CONCLUSIONS: Compared to a diagnosed fibromyalgia patient, a not diagnosed patient in Spain represents an incremental cost of €421 from the health care payer perspective.

COSTS AVOIDED BY DIAGNOSING FIBROMYALGIA IN FRENCH PATIENTS
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OBJECTIVES: To estimate the costs savings in outpatient medical resource use associated with diagnosing fibromyalgia during the four years after fibromyalgia diagnosis, METHODS: A French expert panel, involving 33 general practitioners (GPs) and 27 rheumatologists, was questioned in 2007 by means of a questionnaire describing the UK prescriptions registered in the General Practice Research Database between January 1998 and March 2003 (2260 fibromyalgia patients). Participating experts were asked to describe their clinical practice compared to the UK prescriptions in terms of diagnostic tests, drugs, consultations...
and referrals, over a period of 4 years before diagnosis to 4 years—plus after diagnosis using one year intervals. Poisson loglinear regression models, published for the UK, allowed to estimate the medical resources consumed if no diagnosis had been established. The impact of diagnosis was evaluated for each of these medical resources. Costs were calculated by multiplying resource use with corresponding French unit costs ($; 2007; both public health care payer perspective and societal perspective including patient co-payments). RESULTS: This study confirms previously published results for the UK: whereas costs gradually increase before diagnosis, a stagnation in costs increase occurs in the year after diagnosis, subsequently followed by a moderate decrease afterwards. The same trend was observed whether the panel consisted of GP or rheumatologists. The savings made as a result of fibromyalgia diagnosis add up to €126 per patient and per year in France from the health care system perspective and €184 from a societal perspective. GP visits, diagnostic tests, drugs and referrals to specialists represent respectively 37%, 23%, 12% and 8% of these savings. CONCLUSIONS: Compared to a diagnosed fibromyalgia patient, a not diagnosed patient represents an incremental cost of €126 from the public health care payer perspective, mainly due to medical nomadism and multiplication of investigations and prescriptions.

PM531
OSTEOARTHRITIS AND JOB ABSENTEEISM COSTS: EVIDENCE FROM U.S. NATIONAL SURVEY DATA
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OBJECTIVES: Osteoarthritis is a chronic disease affecting approximately 20 million persons in the United States. Yet, the financial and societal costs to patients, insurers, and society from osteoarthritis remains poorly understood. METHODS: Using data from the Medical Expenditure Panel Survey (MEPS) a large, nationally-representative database from the United States, this study performs bivariate and multivariate analyses to quantify the relationships between osteoarthritis and annual health care costs to patients, insurers, and society. Individual and nationally-aggregated cost estimates will be provided. RESULTS: Overall annual health care costs are dramatically higher in subjects with a diagnosis of osteoarthritis than in subjects without osteoarthritis ($10,803 vs $3,427, p < 0.01). This cost differential is particularly great among African-Americans with osteoarthritis compared to African-Americans without osteoarthritis ($13,937 vs $3,293, p < 0.01). This reflects the high prevalence of osteoarthritis among African-Americans. The total cost of osteoarthritis is dramatically and significantly lower (p < 0.01) among uninsured subjects ($2,875) than among subjects with private insurance ($11,798) or private ($11,093) insurance. This suggests that uninsured subjects with osteoarthritis are facing serious health care access problems. Large differences in total costs from osteoarthritis persist when the sample is stratified by age, gender, educational attainment, insurance status, weight classification, and geographic location. Out-of-pocket health care costs are much higher among subjects with osteoarthritis ($1757 vs. $649, p < 0.01) and are also higher for insurers ($9047 vs. $2279, p < 0.01). CONCLUSIONS: These findings indicate that the cost burden from osteoarthritis is quite large for all groups and falls disproportionately on African-Americans and uninsured individuals.

PM532
THE DIRECT HEALTH CARE COSTS OF OSTEOARTHRITIS: EVIDENCE FROM US NATIONAL SURVEY DATA
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OBJECTIVES: Osteoarthritis is a major debilitating disease affecting approximately 20 million persons in the United States.

PM533
HEALTH ECONOMIC EVALUATION OF OUTPATIENT MANAGEMENT OF FIBROMYALGIA IN SPAIN
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OBJECTIVES: To estimate the medical and non-medical resources use and related costs from the health insurance and societal perspective, in the management of fibromyalgia patients in Spain, METHODS: A questionnaire was created based on the resources use from 2260 fibromyalgia patients extracted from the General Practice Research Database in United-Kingdom. Local experts were asked to compare their own clinical practice to UK prescriptions and resource use, over a period of four years before diagnosis to four years plus years after diagnosis. Prescription data related to paramedical and alternative care were also collected. Costs were calculated by multiplying prescribed resource use with corresponding Spanish unit costs ($; 2007; both public health care payer perspective and societal perspective including patient co-payments). Inpatient care and productivity loss were not considered. RESULTS: The mean medical treatment cost represents €536 per patient per year from the health care payer perspective (i.e. 74% visits cost, 14% drugs cost, and 12% diagnostic tests cost) and €549 from the societal perspective. If paramedical and alternative treatments are included, the estimated cost of fibromyalgia is €674 per patient per year from a societal perspective and €536 from a health care payer perspective. The costs of paramedical and alternative treatments represent 18.5% of the total costs (of which 73% paramedical acts, 23% alternative treatment and 4% food supplements). The annual patient co-payment is estimated at 138 euros. CONCLUSIONS: In Spain, the cost of outpatient management of fibromyalgia is estimated at €674 per patient per year from a societal perspective and at €536 from the public health care payer perspective.