SAT0250 COST OF HEALTH CARE IN DUTCH FIBROMYALGIA PATIENTS: A RETROSPECTIVE SURVEY

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Background

Objectives To estimate the cost of health care in primary fibromyalgia (FM) patients.

Methods All persons diagnosed as FM in our rheumatology outpatient clinic during the last 3 years and members of the Dutch FM patient association were invited to participate in a study on the social impact of FM. Only persons fulfilling ACR criteria for FM, aged 18–65, and without significant co-morbidity, were included. They completed a questionnaire on the impact of FM in the preceding six months, with questions regarding the type, amount and cost of health care they had received during this period. Mean cost was estimated using standardised prizes in Dutch guilders and transformed to Euros (?).

Results The questionnaire was completed by 135 persons (mean age 47 years, standard deviation SD 8.6, 128 females). They reported a mean number of 4 visits (SD 3) to their general practitioner for the six month period, (two of these (SD 2) because of FM) and a mean of 2 visits (SD 2) to medical specialists and 13 visits (SD 15) to health professionals, mainly physiotherapists. One person visited a rehabilitation centre for 1 day per week, 8 patients were admitted to hospital for not-FM related reasons. The mean cost of analgesics, anti-depressants and tranquillisers per six months was ? 52. Apart from this, a reported average of ? 17 was paid for homeopathic and other alternative drugs. Forty-two persons visited complementary or alternative therapists, at a mean cost of ? 61 per person. Participants reported an average of 10.8 (SD 31.5) hours of reimbursed domestic help. A mean sum of ? 159 was paid for devices and adaptations. The table shows estimated costs. Overall health care costs per person per year were ? 2333.

Discussion Since this is not a population-based study, we should consider the possibility of selection bias. On the other hand, in our retrospective study design recall bias may have caused an underestimation of true costs. Although exact data are lacking, we expect that cost of health professionals, complementary and alternative medicine and domestic help are mainly FM-related.

The estimated cost of health care for Dutch women aged 45–49 year is ? 1470 per person per year.

Abstract SAT0250 Table 1

	Total cost	FM-related cost
General practitioner	107	45
Medical specialist	174	?
Health professionals (mainly physiotherapy)	482	?
Hospital admission	457	80
Medication	254	104
Complementary and alternative medicine	157	?
Reimbursed domestic help	204	?
Devices and adaptations	318	318

Total and FM-related cost in Euros per person per year.

Conclusion The cost of health care in Dutch FM patients is approximately 60% higher than in the age-related general

population. Therefore FM is not only a problem in terms of quality of life, but also in terms of health care economics.

SAT0251 AN EVALUATION OF TELEHEALTH TECHNOLOGY IN PROVISION OF DISTANT AND GLOBAL RHEUMATOLOGY CONSULTS

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Background The availability of rheumatology consultations is taken for granted in many parts of the world, but are less readily available in others, the principal barriers being either geographical or absence of suitably trained specialists. One way by which these two barriers can be overcome is by taking the consultation to the patient but in many circumstances this is not very practical. The development of telehealth technology using high quality land-line or satellite linkages can result in bring specialty consultation to patients where such barriers make them inaccessible.

Objectives This project was undertaken to evaluate the feasibility, practicality and acceptability of telehealth consults to a remote area where availability of traditional consults has not previously been available.

Methods A University urban-based rheumatologist has been linked to a family physician in a remote area 750 km from the consultant's location and which is normally only accessible by land assuming good weather conditions. The specialist and referring physician are linked by satellite transmission for a period of two hours on a monthly basis. During each time period a minimum of 6 patients are reviewed. The physician presents the reason for the consultation, which is supplemented by the patient. Appropriate examination is undertaken by the referring physician under observation and direction from the consultant. Issues relating to diagnosis and management of the problem are dealt through 3-way communication between the referring physician, the consultant and the patient. Each of the 3 parties fills in an evaluation form as to the perceived effectiveness and acceptability of the process.

Results Over 100 patient consultations are available for evaluation. The distribution of diagnoses in the telehealth clinics does not differ significantly from those seen in the urban university referral centre. On no occasion was it felt necessary for the patient to be transferred to the referral centre and all medical issues were appropriately dealt with through the telehealth consultation. All 3 parties felt that the process was an effective and acceptable alternative to the traditional consultation. A time and cost benefit analysis showed that there was savings in time, both for the specialist and/or the patient. A cost analysis demonstrated that a total number of 250 consultations per year resulted in cost savings using the telehealth consult rather than the traditional consultation. Additional benefits were seen to be the enhanced 3-way communication between the referring physician, the specialist and the patient, and a significant continuing professional development activity for the referring physician. The disadvantage of the consultation not being able to have direct physical contact with the patient was largely overcome assuming appropriate clinical skill of the referring physician.

Conclusion Telehealth technology has been used by a wide variety of subspecialties for delivering consultations to remote areas, but has not been evaluated in rheumatology. We conclude that this technology is both feasible, practical and acceptable as a means of delivery of Rheumatology specialists consultations and

could significantly facilitate dissemination of accessibility to rheumatologists on a global scale particularly to remote areas where the subspecialty is not now available.

SAT0252 THE IMPACT OF RHEUMATOID ARTHRITIS ON EMPLOYMENT STATUS AND SOCIAL NETWORK: A CROSS-SECTIONAL STUDY OF 146 PATIENTS

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Background Rheumatoid arthritis (RA) is recognised as one of the most disabling rheumatic diseases. Work disability and social impairment are frequently overlooked consequences of RA.

Objectives (1) to evaluate the prevalence of work disability; (2) to evaluate the impact of the disease on the social network in patients with rheumatoid arthritis (RA).

Methods We submitted a self-report questionnaire concerning RA impact on employment status and social support network to a cohort of 229 patients with RA, fulfilling the 1987 ACR criteria, followed in a hospital-based outpatient rheumatology clinic. 146 patients (63.8%) returned the completed questionnaire (female = 88.4%, male = 11.6%; mean age = 56 years; mean disease duration = 13.4 ± 8.1 years; RF positive = 73.8%; mean Larsen score = 50.6; ACR functional class I ? 20.4%, II ? 26.0%, III ? 30.3%, IV ? 12.7%).

Results 83.9% of the patients had less than 7 years of formal education. 70.2% had a monthly income of less than 500 euros. 58.7% of the patients were retired and 2.9% unemployed. From these patients, 84.5% had stopped working due to RA. From the employed patients, 5.8% were currently on leave. From all patients, 83.1% had to take a leave at least once due to RA. The mean total time on leave was 587 days per patient. 86.3% of the patients reported that RA compromised their capability to earn money. 81.4% of the patients were married, 7.9% single, 2.9% divorced or separated and 7.9% widowed. All the divorced or separated patients related their status to RA. 88.4% of the patients live with spouse or first grade relatives. Only 2.7% reported to live alone. 72.8% of the patients depend on escort for physician visits, in most of the cases (92.4%) by the spouse. A minority of patients may rely on institutional social support: 7.2% live in a old age residence, 11.2% have access to a day-care centre, 13.3% to a social worker, 12.3% to a religious association and 8.2% to voluntary workers. 89.6% of the patients reported that RA jeopardised the ability to engage in their previous leisure activities.

Conclusion There was a high prevalence of permanent and temporary work disability related to RA in this cohort. This may be related to the high disease duration of this group. Most patients rely on social support from the family. The impact of RA on marital status was limited, but much more extensive on leisure activities.

SAT0253 LESS USE OF GASTROINTESTINAL (GI) PROTECTIVE AGENTS AND GI-RELATED PROCEDURES WITH ROFECOXIB VS. NAPROXEN IN THE VIGOUR (VIOXX GI OUTCOMES RESEARCH) STUDY

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Background The VIGOUR Study was a randomised, double-blind, clinical trial assessing the GI safety of rofecoxib 50 mg, once daily (n = 4047) versus naproxen 500 mg twice daily (n = 4029) in patients with rheumatoid arthritis. The mean age was 58 years; 80% of patients were female; 8% had a prior history of a GI ulcer or bleed; 82% reported NSAID use at baseline; 21% reported dyspepsia within 14 days prior to baseline; 56% took concomitant corticosteroids for their RA; the treatment groups were not different in these respects. The median duration of follow-up was 9.0 months, the maximum was 13 months.

Objectives To compare the rates of usage of gastroprotective agents (GPAs) and upper GI diagnostic procedures in patients treated with rofecoxib, a highly selective COX-2 inhibitor, compared to naproxen in the VIGOUR Study.

Methods We compared the treatment groups on their rates of new GPA usage (H2 receptor antagonists [H2RAs], proton pump inhibitors [PPIs], sucralfate, and prostaglandin analogues initiated after randomization), and investigator-initiated upper GI diagnostic radiologic and endoscopic procedures. Study participants were permitted to take OTC doses of H2RA's; however, use of prescription GPA's required discontinuation from the study. Use of upper GI diagnostic procedures was based on the investigators' clinical judgment; there were no guidelines or restrictions on their use. Additional analyses were done in the subset of patients (n = 2937) reporting GI adverse experiences (AEs). 95% confidence intervals on rate ratios (RR) of rofecoxib to naproxen were calculated.

Results The incidence of confirmed intestinal perforations, ulcerations, and bleeds (PUBs), the primary endpoint in VIGOUR, was significantly lower with rofecoxib compared to naproxen (2.1% vs 4.5% per year; $p < 0.001$, relative risk 0.46). Patients treated with rofecoxib had lower rates of new GPA usage (11.2% vs 14.5%, RR = 0.77, CI: 0.68–0.87) than those treated with naproxen. Less use of H2RAs and PPIs occurred in the rofecoxib group than the naproxen group (H2RAs: 8.2% vs. 10.6%, RR = 0.77, CI: 0.67–0.89; PPIs: 3.8% vs. 5.6%, RR = 0.68, CI: 0.56–0.84). There were no significant differences between treatment groups in new prescriptions of prostaglandin analogues and sucralfate; few patients received these medications. Use of upper GI procedures was lower (4.3% vs. 5.9%, RR = 0.74, CI: 0.61–0.90) for patients treated with rofecoxib than for patients treated with naproxen. Among patients reporting GI AEs, those treated with rofecoxib required fewer new GPAs (25.5% vs. 32.2%, RR = 0.76, CI: 0.67–0.87) and upper GI procedures (11.5% vs. 14.7%, RR = 0.77, CI: 0.63–0.94) than did those treated with naproxen.

Conclusion In the VIGOUR Study, RA patients treated with the highly selective COX-2 inhibitor rofecoxib for up to 13 months had significantly fewer PUBs, required fewer new prescriptions for PPIs and H2RAs, and had fewer GI procedures than patients treated with naproxen.