at least one ICD10 code (M300, M301, M313, or M318); 2) having at least one ICD10 code (M300, M301, M313, or M318); 3) having at least one hospitalization during the observation period; 4) prescription of oral corticosteroids with prednisolone-equivalent dosage ≥30 mg/day, methylprednisolone pulse therapy, immunosuppressive drugs (cyclophosphamide [IVCy], methotrexate, or mycophenolate mofetil), or rituximab (RTX) during hospitalization between April 2008 and April 2017; and 3) having at least 7 days of hospitalization. The observation started from the next day of discharge from the first hospitalization for RT and ended at 24 months later, the month of loss of follow-up, or April 2017. We described the frequency of hospitalization and calculated direct medical costs (per month) during the observation. We analyzed medical costs from a societal perspective. We classified reasons of hospitalization into 3 categories: intensification of treatments for AAV, AAV MT including IVCY or RTX treatments, and comorbidities (infection, cardiovascular disease [CVD], malignancy, and others) using ICD10 codes plus treatments or interventions during the hospitalization.

Results: In this study, 1,703 patients with AAV were included. The median [IQR] age was 72 [63, 79] years and 55.7% were female. The total number of hospitalization was 1,897 in 863 patients (50.7%). Among the hospitalizations, 296 hospitalization in 235 patients were categorized as intensification of treatments for AAV, 627 hospitalization in 297 patients were AAV MT, and 974 hospitalization in 572 patients were categorized as comorbidities. In the last category, infections were most frequent (220), followed by malignancy (54) and CVD (15). The mean direct medical costs in patients with at least one hospitalization was approximately 3.5 times as high as that in those without hospitalization.


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