**Title: Cost-effectiveness analysis of the NIRUDAK clinical diagnostic model for dehydration severity in patients over five years**

**Introduction**

Accounting for over 6.5 billion cases and 1.4 million deaths in 2019, diarrheal diseases are a major cause of morbidity and mortality and exert a heavy burden on health care systems worldwide (1). As the severity of diarrheal disease can vary widely, accurately assessing dehydration status remains the most critical step in acute diarrhea management. Episodes of acute diarrhea lead to dehydration, and existing care guidelines, namely from the World Health Organization (WHO), base treatment on categorical estimates for fluid resuscitation.

The Novel, Innovative Research for Understanding Dehydration in Adults and Kids (NIRUDAK, meaning dehydrated in Bangla) model predicts percentage dehydration (fluid deficit) in individuals with acute diarrhea to better target treatment and avoid the potential sequelae of over or under resuscitation. Unlike the WHO Integrated Management of Adolescent and Adult Illness (IMAAI) algorithm, which are based on the number of symptoms of dehydration exhibited by the patient, the NIRUDAK model employs clinical measurements as inputs into a machine learning model (2). Previous analysis has demonstrated that the NIRUDAK outperforms the WHO algorithm in terms of accuracy and reliability (3).

The aim of this study was to compare the cost-effectiveness of the NIRUDAK model to WHO algorithm in treating patients over five years of age experiencing acute dehydration due to diarrhea. This study represents the first comparison of the cost effectiveness of the NIRUDAK model and the WHO algorithm.

**Materials and Methods**

*Study Procedures*

Data were collected as part of the NIRUDAK study, a prospective cohort study of patients over five years presenting with diarrhea to the International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b) Dhaka Hospital in Bangladesh between March 2019 and March 2020. Patients were randomly screened for participation in the study upon arrival to the hospital (1). Local nurses independently assessed patients for symptoms of dehydration on arrival and continued to collect and record patient weight and amount of fluid administered until the patients were discharged. The true dehydration status (percent dehydration) was determined based on the patient’s weight at the time of admission to the hospital and their “post-illness” weight at the time of discharge from the hospital. Calculated percent dehydration was stratified into three categories of dehydration severity — no, some, and severe — based on current standards in the literature (4–6). The WHO algorithm and NIRUDAK model both attempt to predict patients’ true dehydration status by classifying patients into one of three predicted categories of dehydration severity: no, some, or severe.

*Data Analysis*

Costs for treatment were calculated using data from icddr,b. Total costs for each individual patient in the study were calculated based on the type and total amount of fluid each patient received, associated equipment costs, length of stay at the hospital, and wages lost while in the hospital. All costs were received directly from icddr,b. All exchange rate conversions from Bangladeshi taka (BDT) to United States dollar (USD) were conducted using data from the World Bank (7,8). Costs are summarized in Table 1.

A decision tree (Figure 1) was constructed to demonstrate DALYs and costs for each possible combination of true dehydration status and model-assigned dehydration status. Cost was calculated for each branch of the decision tree by taking the mean cost of all patients in that branch. DALYs were calculated as a sum of years of life lost due to illness and years lived with disability. Per convention, years of life lost for each patient were based on Japanese life tables which outline life expectancies at specified ages (9,10). Years lived with disability were calculated based on estimates from the Global Burden of Disease study (11,12). DALYs for each branch of the decision tree were calculated by taking the mean number of DALYs for all patients in that branch.

For the base case analysis, the probability of death from serious cases of undertreatment (i.e., if a patient had severe dehydration but was predicted to have some or no dehydration by the model) was estimated to be 100% based on clinical input from physicians who have practiced at icddr,b. The probability of death from serious cases of overtreatment (e.g., if ) was estimated to be 2% based on prior studies of undertreatment in the context of dehydration due to diarrheal illness. An initial incremental cost-effectiveness ratio (ICER) was calculated using these data to serve as our base case results.

Two-way sensitivity analyses were then conducted; here, the probability of death from under- and overtreatment were both taken as variable. Per WHO recommendations, two willingness-to-pay thresholds were used in analysis: two- and three-times the 2019 Bangladeshi gross domestic product (GDP) per capita in USD (13).

[JP: METHODS — PSA & COST-EFFECTIVENESS ACCEPTABILITY CURVE/FRONTIER METHODS]

This study has been approved by the Ethical Review Committee of icddr,b and the Rhode Island Hospital Institutional Review Board.

**Results**

Median age for enrolled patients was 35. Demographic information is summarized in Table 2.

[JP: RESULTS — PSA & COST-EFFECTIVENESS ACCEPTABILITY CURVE/FRONTIER]

**Discussion**

*Limitations*

*Future Directions*

**Conclusion**

**REFERENCES**

1. Levine AC, Barry MA, Gainey M, Nasrin S, Qu K, Schmid CH, et al. Derivation of the first clinical diagnostic models for dehydration severity in patients over five years with acute diarrhea. PLoS Negl Trop Dis. 2021 Mar 10;15(3):e0009266.

2. Acute Care: Integrated Management of Adolescent and Adult Illness. World Health Organization; 2004.

3. Gainey M, Qu K, Garbern SC, Barry MA, Lee JA, Nasrin S, et al. Assessing the performance of clinical diagnostic models for dehydration among patients with cholera and undernutrition in Bangladesh. Trop Med Int Health. 2021;26(11):1512–25.

4. Duggan C, Santosham M, Glass R. The Management of Acute Diarrhea in Children: Oral Rehydration, Maintenance, and Nutritional Therapy [Internet]. [cited 2023 Jul 28]. Available from: https://www.cdc.gov/mmwr/preview/mmwrhtml/00018677.htm

5. Levine AC, Glavis-Bloom J, Modi P, Nasrin S, Rege S, Chu C, et al. Empirically Derived Dehydration Scoring and Decision Tree Models for Children With Diarrhea: Assessment and Internal Validation in a Prospective Cohort Study in Dhaka, Bangladesh. Glob Health Sci Pract. 2015 Sep 10;3(3):405–18.

6. Levine AC, Glavis-Bloom J, Modi P, Nasrin S, Atika B, Rege S, et al. External validation of the DHAKA score and comparison with the current IMCI algorithm for the assessment of dehydration in children with diarrhoea: a prospective cohort study. Lancet Glob Health. 2016 Oct 1;4(10):e744–51.

7. World Bank Open Data [Internet]. [cited 2023 Jul 27]. GDP, PPP (current international $) - Bangladesh. Available from: https://data.worldbank.org/indicator/NY.GDP.MKTP.PP.CD?locations=BD

8. World Bank Open Data [Internet]. [cited 2023 Jul 27]. GDP Per Capita (current US$) - Bangladesh. Available from: https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=BD

9. Abridged Life Tables for Japan 2019. Ministry of Health, Labour and Welfare, Government of Japan;

10. Menken M, Munsat TL, Toole JF. The Global Burden of Disease Study: Implications for Neurology. Arch Neurol. 2000 Mar 1;57(3):418–20.

11. Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2019 (GBD 2019) Disability Weights [Internet]. Institute for Health Metrics and Evaluation (IHME); 2020 [cited 2023 Jul 28]. Available from: http://ghdx.healthdata.org/record/ihme-data/gbd-2019-disability-weights

12. Vos T, Flaxman AD, Naghavi M, Lozano R, Michaud C, Ezzati M, et al. Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. The Lancet. 2012 Dec 15;380(9859):2163–96.

13. Making Choices in Health: WHO Guide to Cost-effectiveness Analysis. World Health Organization; 2003. 364 p.