

Healthcare Resource Utilization in Patients with Myeloproliferative Neoplasms

A Danish Nationwide Matched Cohort Study

Christensen, Sarah Friis; Svingel, Lise Skovgaard; Kjærsgaard, Anders; Stenling, Anna; Darvalics, Bianka; Paulsson, Björn; Andersen, Christen Lykkegaard; Christiansen, Christian Fynbo; Stentoft, Jesper; Starklint, Jørn; Severinsen, Marianne Tang; Clausen, Mette Borg; Hilsøe, Morten Hagemann; Hasselbalch, Hans Carl; Frederiksen, Henrik; Mikkelsen, Ellen Margrethe; Bak, Marie

Published in:

European Journal of Haematology

DOI (link to publication from Publisher):

[10.1111/ejh.13841](https://doi.org/10.1111/ejh.13841)

Creative Commons License

CC BY-NC-ND 4.0

Publication date:

2022

Document Version

Publisher's PDF, also known as Version of record

[Link to publication from Aalborg University](#)

Citation for published version (APA):

Christensen, S. F., Svingel, L. S., Kjærsgaard, A., Stenling, A., Darvalics, B., Paulsson, B., Andersen, C. L., Christiansen, C. F., Stentoft, J., Starklint, J., Severinsen, M. T., Clausen, M. B., Hilsøe, M. H., Hasselbalch, H. C., Frederiksen, H., Mikkelsen, E. M., & Bak, M. (2022). Healthcare Resource Utilization in Patients with Myeloproliferative Neoplasms: A Danish Nationwide Matched Cohort Study. *European Journal of Haematology*, 109(5), 526-541. <https://doi.org/10.1111/ejh.13841>

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal -

Take down policy

If you believe that this document breaches copyright please contact us at vbn@aub.aau.dk providing details, and we will remove access to the work immediately and investigate your claim.

Downloaded from vbn.aau.dk on: December 04, 2025

ORIGINAL ARTICLE



Healthcare resource utilization in patients with myeloproliferative neoplasms: A Danish nationwide matched cohort study

Sarah Friis Christensen¹ | Lise Skovgaard Svingel² | Anders Kjærsgaard² | Anna Stenling³ | Bianka Darvalics² | Björn Paulsson³ | Christen Lykkegaard Andersen^{4,5} | Christian Fynbo Christiansen² | Jesper Stentoft⁶ | Jørn Starklint⁷ | Marianne Tang Severinsen⁸ | Mette Borg Clausen⁴ | Morten Hagemann Hilsøe⁹ | Hans Carl Hasselbalch¹ | Henrik Frederiksen¹⁰ | Ellen Margrethe Mikkelsen² | Marie Bak^{1,4}

¹Department of Hematology, Zealand University Hospital, Roskilde, Denmark

²Department of Clinical Epidemiology, Department of Clinical Medicine, Aarhus University Hospital and Aarhus University, Aarhus, Denmark

³Novartis Sverige AB, Kista, Sweden

⁴Department of Hematology, Copenhagen University Hospital, Rigshospitalet, Denmark

⁵The Research Unit for General Practice and Section of General Practice, Department of Public Health, University of Copenhagen, Copenhagen, Denmark

⁶Department of Hematology, Aarhus University Hospital, Aarhus, Denmark

⁷Department of Hematology, Holstebro Hospital, Holstebro, Denmark

⁸Department of Hematology, Aalborg University Hospital, Aalborg, Denmark

⁹Department of Hematology, Hospital South West Jutland, Esbjerg, Denmark

¹⁰Department of Hematology, Odense University Hospital, Odense, Denmark

Correspondence

Sarah Friis Christensen, Department of Hematology, Zealand University Hospital, Vestermarksvej 9, 4000 Roskilde, Denmark.
Email: safc@regionsjaelland.dk

Funding information

Novartis

Abstract

Few studies have assessed healthcare resource utilization (HRU) in patients with Philadelphia-negative myeloproliferative neoplasms (MPN) using a matched cohort design. Further, no detailed assessment of HRU in the years preceding an MPN diagnosis exists. We conducted a registry-based nationwide Danish cohort study, including patients with essential thrombocythemia, polycythemia vera, myelofibrosis, and unclassifiable MPN diagnosed between January 2010 and December 2016. HRU data were summarized annually from 2 years before MPN diagnosis until emigration, death, or end of study (December 2017). We included 3342 MPN patients and 32 737 comparisons without an MPN diagnosis, matched on sex, age, region of residence, and level of education. During the study period, the difference in HRU (rate ratio) between patients and matched comparisons ranged from 1.0 to 1.5 for general practitioner contacts, 0.9 to 2.2 for hospitalizations, 0.9 to 3.8 for inpatient days, 1.0 to 4.0 for outpatient visits, 1.3 to 2.1 for emergency department visits, and 1.0 to 4.1 for treatments/examinations. In conclusion, MPN patients had overall higher HRU than the matched comparisons throughout the follow-up period (maximum 8 years). Further, MPN patients had substantially increased HRU in both the primary and secondary healthcare sector in the 2 years preceding the diagnosis.

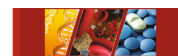
KEYWORDS

ambulatory care, case-control studies, early diagnosis, epidemiology, general practice, health resources, healthcare costs, hospitalization, myeloproliferative disorder, registries

Sarah Friis Christensen, Lise Skovgaard Svingel, Ellen Margrethe Mikkelsen, and Marie Bak contributed equally to this work.

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2022 The Authors. *European Journal of Haematology* published by John Wiley & Sons Ltd.



1 | INTRODUCTION

The myeloproliferative neoplasms (MPNs), comprising essential thrombocythemia (ET), polycythemia vera (PV), myelofibrosis (MF), and MPN, unclassifiable (MPN-U), are acquired hematopoietic stem cell cancers.^{1,2} The clinical presentation of patients with MPN ranges from nearly asymptomatic patients managing full-time jobs to debilitated patients in need of frequent hospitalization. Prevalent symptoms include fatigue, pruritus, constitutional symptoms, abdominal discomfort, and early satiety, largely attributable to splenomegaly—a common manifestation of PV and MF.^{3,4} Besides splenomegaly, MPN complications encompass thrombosis, hemorrhage, infections, bone marrow failure, and progression to acute myeloid leukemia.^{4,5} In addition, recent research has documented an increased risk of several chronic diseases (e.g., cardiovascular diseases, age-related macular degeneration, chronic kidney disease, and inflammatory bowel disease) and second cancers in MPN patients.^{6–15} The development of targeted treatment (JAK1/2 inhibitors) has significantly improved constitutional symptoms and splenomegaly in some MPN patients, but for many patients, the symptom burden persists despite treatment.¹⁶ Bone marrow transplantation is a potentially curative treatment, but only few patients undergo transplantation due to high treatment-related mortality.^{2,17} Given the chronic nature of the MPNs and the substantial morbidity burden, MPN patients have a continuous need for health care during the lifelong course of disease.

Only two studies have examined healthcare resource utilization (HRU) in patients with MPN and compared with matched individuals without MPN.^{18,19} In a cross-sectional study using US claim databases, Mehta et al. found that all aspects of HRU, including outpatient consultations, inpatient days, emergency room visits, and pharmacy costs (e.g., number of prescriptions), were higher among MPN patients compared with matched comparisons without MPN.¹⁸ Similarly, in a population-based retrospective study using data from Ontario's administrative health databases, Bankar et al. showed that MPN patients had a higher HRU than matched comparisons for all examined HRU measures, except long-term care.¹⁹

However, so far, no studies reporting HRU from nationwide cohorts of MPN patients exist, and neither of the two prior studies determined the HRU of all four MPN subtypes. Furthermore, accumulating research demonstrates that MPN-associated driver mutations, complications, and symptoms are often present several years before patients are diagnosed with MPN.^{20–22} Hence, it seems plausible that HRU might increase in the years prior to the time of MPN diagnosis as well. In support of this theory, the study by Bankar et al. reported that, based on a comorbidity score calculated from pre-diagnostic characteristics, MPN patients were more likely than comparisons to have high HRU around time of diagnosis.¹⁹ However, individual-level data by MPN subtype and type of HRU (e.g., outpatient consultations, inpatient days, hospital treatments, emergency department [ED] visits, and general practitioner [GP] contacts) were not collected in the years preceding the MPN diagnosis.

Up-to-date real-world data on HRU is essential for healthcare planning, health economic analysis, and decisions on implementation of new treatments. Hence, we aimed to assess pre- and post-diagnostic HRU in

nationwide cohorts of Danish MPN patients and matched comparisons without MPN.

2 | MATERIALS AND METHODS

2.1 | Study design and setting

In this descriptive, matched cohort study, we used data from population-based Danish registries (Figure S1). The Danish healthcare system provides egalitarian, tax-funded health care for all citizens (approximately 5.7 million),²³ enabling us to study HRU across diagnoses and healthcare sectors.

2.2 | Study population

The study population comprised eight cohorts: four MPN cohorts and four non-MPN cohorts. The MPN cohorts included all patients aged ≥ 18 years with a first-time diagnosis of ET, PV, MF, or MPN-U recorded in the Danish National Chronic Myeloid Neoplasia Registry (DCMR) in the period from January 1, 2010 to December 31, 2016 (Figure S2).²⁴ Patients were diagnosed according to the prevailing World Health Organization diagnostic criteria at time of diagnosis (Table S1). Patients with chronic myeloid leukemia or prefibrotic myelofibrosis were not eligible for inclusion (Figure S3). The non-MPN cohorts (nonET, nonPV, nonMF, and nonMPN-U) were randomly sampled without replacement by matching patients to population comparisons by 1:10 (when data allowed) on sex, age (year of birth), region of residence, and level of education. The index date for patients and their matched comparisons was defined as the date of MPN diagnosis in the DCMR. Patients and comparisons contributed person-time from index date until emigration, death, or end of study on December 31, 2017 (i.e., maximum 8 years), whichever came first. In addition, we applied a 2-year pre-diagnosis period preceding the index date.

2.3 | Variables and data sources

The DCMR is a national quality registry with $\geq 98\%$ national coverage and 89%–100% completeness of data on patients with MPN.^{24–27}

We linked individual-level data from the DCMR with data from other registries using a unique personal identification number issued by the Danish Civil Registration System to all citizens.²⁸ From the Danish Civil Registration System, we obtained information on sex, age, region of residence, date of emigration, and vital status. Information on level of education was acquired from educational data from Statistics Denmark and classified as short, medium, long, or missing (including no education) according to highest completed education (Table S1).^{29,30} We obtained information on the conditions included in the Charlson Comorbidity Index (CCI) score (Table S1) from 5 years prior to index date from the Danish National Patient Registry (DNPR).^{31,32} The DNPR holds clinical data (according to International Classification of Diseases, 10th revision since 1994) on all somatic hospital admissions since 1977 and all outpatient

**TABLE 1** Baseline characteristics of the study population including comparison cohorts

	ET	nonET	PV	nonPV	MF	nonMF	MPN-U	nonMPN-U
Total number, <i>n</i>	1140	11 181	1109	10 873	533	5217	560	5466
Year of diagnosis, <i>n</i> (%)								
2010	129 (11.3)	1229 (11.0)	128 (11.5)	1208 (11.1)	64 (12.0)	629 (12.1)	72 (12.9)	707 (12.9)
2011	130 (11.4)	1298 (11.6)	129 (11.6)	1301 (12.0)	73 (13.7)	723 (13.9)	77 (13.8)	750 (13.7)
2012	158 (13.9)	1560 (14.0)	146 (13.2)	1425 (13.1)	82 (15.4)	818 (15.7)	75 (13.4)	730 (13.4)
2013	171 (15.0)	1671 (14.9)	155 (14.0)	1549 (14.2)	97 (18.2)	952 (18.2)	73 (13.0)	714 (13.1)
2014	169 (14.8)	1664 (14.9)	204 (18.4)	1994 (18.3)	66 (12.4)	610 (11.7)	84 (15.0)	824 (15.1)
2015	191 (16.8)	1878 (16.8)	178 (16.1)	1725 (15.9)	79 (14.8)	788 (15.1)	85 (15.2)	832 (15.2)
2016	192 (16.8)	1881 (16.8)	169 (15.2)	1671 (15.4)	72 (13.5)	697 (13.4)	94 (16.8)	909 (16.6)
Age, mean (SE)	65.1 (14.6)	64.9 (14.7)	68.1 (12.6)	67.9 (12.6)	71.6 (11.4)	71.4 (11.5)	69.7 (13.4)	69.7 (13.4)
Age, median (IQR)	67 (55, 76)	67 (55, 76)	69 (61, 77)	69 (61, 77)	73 (66, 79)	73 (66, 79)	72 (63, 80)	71 (63, 80)
Age groups, <i>n</i> (%)								
<40	67 (5.9)	682 (6.1)	24 (2.2)	239 (2.2)	9 (1.7)	90 (1.7)	11 (2.0)	109 (2.0)
40–50	137 (12.0)	1368 (12.2)	88 (7.9)	884 (8.1)	17 (3.2)	180 (3.5)	50 (8.9)	470 (8.6)
51–69	444 (38.9)	4318 (38.6)	453 (40.8)	4477 (41.2)	168 (31.5)	1675 (32.1)	189 (33.8)	1873 (34.3)
≥70	492 (43.2)	4813 (43.0)	544 (49.1)	5273 (48.5)	339 (63.6)	3272 (62.7)	310 (55.4)	3014 (55.1)
Sex, <i>n</i> (%)								
Female	689 (60.4)	6746 (60.3)	552 (49.8)	5439 (50.0)	223 (41.8)	2168 (41.6)	291 (52.0)	2847 (52.1)
Male	451 (39.6)	4435 (39.7)	557 (50.2)	5434 (50.0)	310 (58.2)	3049 (58.4)	269 (48.0)	2619 (47.9)
Level of education, <i>n</i> (%)								
Short	355 (31.1)	3537 (31.6)	419 (37.8)	4184 (38.5)	192 (36.0)	1917 (36.7)	221 (39.5)	2203 (40.3)
Medium	430 (37.7)	4305 (38.5)	446 (40.2)	4471 (41.1)	234 (43.9)	2347 (45.0)	224 (40.0)	2217 (40.6)
Long	319 (28.0)	3159 (28.3)	203 (18.3)	2001 (18.4)	84 (15.8)	831 (15.9)	99 (17.7)	974 (17.8)
Missing	36 (3.2)	180 (1.6)	41 (3.7)	217 (2.0)	23 (4.3)	122 (2.3)	16 (2.9)	72 (1.3)
CCI score, ^a <i>n</i> (%)								
0	713 (62.5)	8425 (75.4)	668 (60.2)	7958 (73.2)	301 (56.5)	3544 (67.9)	324 (57.9)	3923 (71.8)



TABLE 1 (Continued)

	ET	nonET	PV	nonPV	MF	nonMF	MPN-U	nonMPN-U
1	230 (20.2)	1312 (11.7)	242 (21.8)	1350 (12.4)	109 (20.5)	755 (14.5)	116 (20.7)	706 (12.9)
>1	197 (17.3)	1444 (12.9)	199 (17.9)	1565 (14.4)	123 (23.1)	918 (17.6)	120 (21.4)	837 (15.3)
Region of residence, n (%)								
Capital Region of Denmark	418 (36.7)	4129 (36.9)	310 (28.0)	3025 (27.8)	185 (34.7)	1823 (34.9)	107 (19.1)	1032 (18.9)
Region Zealand	164 (14.4)	1594 (14.3)	199 (17.9)	1948 (17.9)	150 (28.1)	1475 (28.3)	82 (14.6)	806 (14.7)
Region of Southern Denmark	229 (20.1)	2235 (20.0)	281 (25.3)	2712 (24.9)	106 (19.9)	1031 (19.8)	121 (21.6)	1186 (21.7)
North Denmark Region	49 (4.3)	481 (4.3)	93 (8.4)	926 (8.5)	43 (8.1)	416 (8.0)	141 (25.2)	1364 (25.0)
Central Denmark Region	280 (24.6)	2742 (24.5)	226 (20.4)	2262 (20.8)	49 (9.2)	472 (9.0)	109 (19.5)	1078 (19.7)
Follow-up, years								
Mean (95% CI)	3.8 (3.7–4.0)	3.9 (3.8–3.9)	3.8 (3.7–4.0)	3.9 (3.9–3.9)	3.1 (3.0–3.3)	3.9 (3.9–4.0)	3.3 (3.1–3.4)	3.9 (3.8–4.0)
Median (IQR)	3.6 (2.1–5.3)	3.7 (2.2–5.4)	3.6 (2.3–5.3)	3.6 (2.3–5.5)	2.8 (1.5–4.7)	3.9 (2.2–5.5)	2.8 (1.7–4.8)	3.6 (2.1–5.6)
Individuals who died, n (%)	157 (13.8)	1319 (11.8)	173 (15.6)	1420 (13.1)	222 (41.7)	1006 (19.3)	198 (35.4)	882 (16.1)

^aCharlson Comorbidity Index score, excluding non-melanoma skin cancer (ICD-10: C44).

and ED visits since 1995. Furthermore, it holds clinical data on surgical procedures, examinations, and certain hospital-administered treatments, including medical treatments in relation to blood cancer.

The HRU study outcome was defined as number of GP contacts (including telephone, email, and in-person contacts with GP) and hospital contacts, hospitalizations (i.e., inpatient episodes), inpatient days, outpatient visits, ED visits, and treatments/examinations as defined in Table S2. Data on number and type of hospital contacts were retrieved from the DNPR.

Information on all types of GP contacts was obtained from the Danish National Health Service Registry, which includes nationwide data on primary care services.³³

HRU was assessed in two observation periods: a 2-year pre-diagnosis period (year –2 and year –1 relative to the index date) and a post-diagnosis follow-up period of maximum 8 years (year 1–8 relative to the index date) (Figure S2).

2.4 | Statistical analysis

Demographic characteristics were described for the MPN and comparison cohorts using frequency (*n*), proportion (%), median and interquartile range (IQR), and mean and standard error. The Wald method with continuity correction was used to calculate the associated 95% confidence intervals (CIs). In addition, median follow-up time and the number of patients who died (all-cause mortality) or emigrated during follow-up were reported.

We described HRU as the annual number of GP contacts and of all types of hospital contacts by median and IQR to describe the distribution of data. This median HRU was calculated for each year of the observation periods as the median number of contacts per person at risk in the cohort on 1 January of each respective year. This was supplemented with computation of the intensity of HRU as mean number of contacts per person-years at risk with 95% CIs for each year of the observation periods. In this way, individuals provided person-time until the date of a censoring event (emigration, death, or end of follow-up). Finally, we calculated and graphically presented rate ratios (RRs) of the intensity of HRU, comparing the four patient cohorts and their respective comparison cohort.

The study was registered by Aarhus University according to Danish and European regulations for data protection (Aarhus University record number 2016-051-000001, # 886).

Data management and analyses of the pseudonomized data were performed on secured servers at Statistics Denmark using SAS 9.4.

3 | RESULTS

3.1 | Participants

We identified 3342 MPN patients in the DCMR resulting in four patient cohorts comprising 1140 ET, 1109 PV, 533 MF, and 560 MPN-U patients (Figure S3). The matched comparison cohorts

TABLE 2 Healthcare resource utilization in ET patients and nonET comparisons pre- and post-diagnosis

Year relative to index	Persons at-risk, n		GP contacts			Hospitalizations			Inpatient days		
	ET	nonET	ET		nonET	ET		nonET	ET		nonET
			Median (IQR) ^a	Mean (95% CI) ^b		Median (IQR) ^a	Mean (95% CI) ^b		Median (IQR) ^a	Mean (95% CI) ^b	
-2	1140	11 181	8 (4-14)	9.8 (9.6-10.0)	7 (3-12)	1 (1-2)	8.8 (8.8-8.9)	1 (0-1)	2 (1-7)	7.4 (7.1-7.8)	1 (0-4)
-1	1140	11 181	12 (7-18)	13.5 (13.3-13.7)	7 (3-13)	1 (1-2)	9.0 (9.0-9.1)	1 (0-1)	4 (1-9)	8.5 (8.2-8.8)	1 (0-4)
1	1140	11 181	11 (5-18)	13.1 (12.9-13.3)	7 (3-13)	1 (1-2)	9.3 (9.3-9.4)	1 (0-1)	2 (1-8)	8.1 (7.8-8.4)	1 (0-6)
2	1140	10 832	10 (5-16)	13.0 (12.8-13.3)	7 (3-13)	1 (1-2)	10.2 (10.2-10.3)	1 (0-1)	3 (1-11)	10.9 (10.5-11.3)	1 (0-5)
3	889	8741	9 (5-15)	12.9 (12.6-13.2)	7 (3-13)	1 (1-2)	10.6 (10.5-10.7)	1 (0-1)	3 (1-11)	8.8 (8.3-9.2)	1 (0-6)
4	673	6762	9 (4-15)	12.6 (12.3-12.8)	7 (3-13)	1 (1-2)	10.7 (10.6-10.8)	1 (0-1)	4 (1-11)	9.4 (8.9-10.0)	1 (0-5)
5	500	5068	9 (4-14)	12.7 (12.4-13.0)	7 (3-13)	1 (1-2)	11.0 (10.9-11.1)	1 (0-2)	3 (1-10)	8.4 (7.9-9.0)	1 (0-6)
6	343	3468	9 (4-14)	13.8 (13.3-14.2)	7 (3-13)	1 (1-2)	12.2 (12.1-12.3)	1 (0-2)	3 (1-9)	8.9 (8.1-9.7)	1 (0-5)
7	194	2046	9 (4-16)	15.1 (14.5-15.7)	7 (4-14)	1 (1-2)	13.1 (12.9-13.3)	1 (0-2)	3 (1-8)	8.1 (7.1-9.2)	1 (0-6)
8	89	965	7 (4-15)	21.1 (19.8-22.5)	7 (3-13)	1 (1-2)	18.9 (18.5-19.3)	1 (0-1)	2 (1-5)	9.3 (7.5-11.5)	1 (0-6)
Treatments/examinations											
Year relative to index	Persons at-risk, n		Outpatient visits			ED visits			ET		
	ET	nonET	ET		nonET	ET		nonET	ET		nonET
			Median (IQR) ^a	Mean (95% CI) ^b		Median (IQR) ^a	Mean (95% CI) ^b		Median (IQR) ^a	Mean (95% CI) ^b	
-2	1140	11 181	2 (1-4)	3.7 (3.5-3.8)	1 (1-3)	1 (1-1)	2.9 (2.9-3.0)	1 (0-1)	3 (1-6)	5.6 (5.4-5.8)	2 (1-5)
-1	1140	11 181	3 (2-6)	4.5 (4.3-4.6)	2 (1-4)	1 (1-2)	3.6 (3.6-3.6)	1 (0-1)	4 (2-8)	7.0 (6.8-7.1)	2 (1-6)
1	1140	11 181	9 (5-13)	10.1 (9.9-10.3)	2 (1-4)	1 (1-1)	3.7 (3.7-3.8)	1 (0-1)	12 (6-18)	14.6 (14.3-14.8)	2 (1-6)
2	1140	10 832	5 (2-8)	6.9 (6.7-7.1)	2 (1-4)	1 (1-2)	3.6 (3.6-3.7)	1 (0-1)	6 (3-12)	10.3 (10.1-10.5)	2 (1-6)
3	889	8741	4 (2-8)	6.4 (6.2-6.7)	2 (1-4)	1 (1-2)	3.8 (3.8-3.9)	1 (0-1)	6 (3-11)	10.4 (10.1-10.6)	2 (1-6)

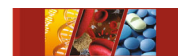


TABLE 2 (Continued)

Year relative to index	Persons at-risk, <i>n</i>		Outpatient visits			ED visits			Treatments/examinations		
	ET	nonET	ET		nonET	ET		nonET	ET		nonET
			Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a
4	673	6762	4 (2-7)	6.5 (6.2-6.7)	2 (1-4)	1 (1-1)	1.5 (1.3-1.8)	1 (0-1)	5 (2-11)	10.2 (9.9-10.5)	2 (1-6)
5	500	5068	4 (2-7)	6.1 (5.8-6.4)	2 (1-4)	1 (1-2)	1.6 (1.4-2.0)	1 (0-1)	5 (2-9)	9.2 (8.9-9.6)	2 (1-6)
6	343	3468	3 (2-7)	5.7 (5.4-6.1)	2 (1-4)	1 (1-1)	1.7 (1.3-2.1)	1 (0-1)	4 (2-10)	8.9 (8.5-9.4)	2 (1-6)
7	194	2046	2 (1-4)	4.5 (4.0-4.9)	2 (1-3)	1 (1-2)	2.0 (1.5-2.7)	1 (0-1)	3 (1-6)	7.8 (7.2-8.4)	2 (1-6)
8	89	965	2 (1-3)	3.9 (3.2-4.7)	1 (1-3)	1 (1-1)	2.5 (1.1-4.8)	1 (0-1)	2 (1-4)	7.4 (6.3-8.5)	2 (1-4)

^aMedian healthcare resource utilization was defined by the median number of contacts, episodes, days, visits, or treatments/examinations per person at risk in the cohort on January 1 of the respective year.

^bMean healthcare intensity was calculated as number of contacts, episodes, days, visits, or treatments/examinations divided by person-years at risk (each individual provided person-time to every year until date of a censoring event).

included 11 181_{nonET}, 10 873_{nonPV}, 5217_{nonMF}, and 5466_{nonMPN-U} comparisons, yielding 32 737_{nonMPN} comparisons.

Median age at MPN diagnosis was 67 years (IQR: 55-76) for ET, 69 years (IQR: 61-77) for PV, 72 years (IQR: 63-80) for MPN-U, and 73 years (IQR: 66-79) for MF patients (Table 1). Women comprised 60% of ET, 52% of MPN-U, 50% of PV, and 42% of MF patients. In all cohorts, most patients had an education of medium length (38%-45% across cohorts). Across MPN subtypes, a smaller proportion of patients (ranging from 57% in MF to 63% in ET) than comparisons (ranging from 68% in_{nonMF} to 75% in_{nonET}) had not been diagnosed with any comorbidity according to CCI at the time of index.

The median follow-up was 3.6 years (IQR: 2.1-5.3) in ET, 3.6 years (IQR: 2.3-5.3) in PV, 2.8 years (IQR: 1.5-4.7) in MF, and 2.8 years (IQR: 1.7-4.8) in MPN-U patients (Table 1). The median follow-up was 3.6-3.9 years across comparison cohorts. During follow-up, 750 MPN patients (22%) and 4627_{nonMPN} comparisons (14%) died (all-cause mortality). The proportion of deaths among ET patients (14%) and PV patients (16%) was similar to that observed in their comparisons, while the proportion of deaths among MPN-U patients (35%) and MF patients (42%) was twofold that in their comparisons (Table 1).

3.2 | Healthcare resource utilization

3.2.1 | Pre-diagnosis period

In the pre-diagnosis period, MPN patients in all cohorts had higher median number of all types of HRU than their matched comparisons (Tables 2-5). Accordingly, the mean number of all types of HRU per person-years at risk, that is, the intensity, was higher among MPN patients than among their comparisons during the 2 years preceding diagnosis, corresponding to RRs >1 (Figure 1 and Table S3). In the pre-diagnosis period, especially during the year preceding diagnosis, the discrepancy between patients and comparisons in terms of RR was greatest for inpatient days (year -1 relative to index: ET, 1.7 [95% CI: 1.6-1.9]; PV, 1.7 [95% CI: 1.6-1.8]; MF, 1.8 [95% CI: 1.7-2.0]; and MPN-U, 3.1 [95% CI: 2.8-3.4]) and ED visits (year -1 relative to index: ET, 1.8 [95% CI: 1.7-1.9]; PV, 1.9 [95% CI: 1.8-2.0]; MF, 1.6 [95% CI: 1.4-1.7]; and MPN-U, 1.8 [95% CI: 1.7-2.0]).

In all four patient cohorts, there was an increase in the median number and intensity of GP contacts, hospital inpatient days, hospital outpatient visits, and hospital treatments/examinations from 2 years before diagnosis to 1 year before diagnosis (Tables 2-5). This pattern was not as pronounced in the four comparison cohorts. Median number and intensity of hospitalizations and ED visits remained stable during the pre-diagnosis period in all cohorts.

3.2.2 | Post-diagnosis period

A common trait for all patient and comparison cohorts was that the median number and intensity of hospitalizations and ED visits remained relatively stable throughout follow-up (Tables 2-5).

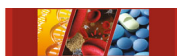


TABLE 3 Healthcare resource utilization in PV patients and non-PV comparisons pre- and post-diagnosis

Year relative to index	Persons at-risk, n		GP contacts			Hospitalizations			Inpatient days		
	PV	non-PV	PV	Median (IQR) ^a	Mean (95% CI) ^b	PV	Median (IQR) ^a	Mean (95% CI) ^b	PV	Median (IQR) ^a	Mean (95% CI) ^b
-2	1109	10 873	8	(3-13)	9.7 (9.5-9.8)	7	(3-13)	9.0 (9.0-9.1)	1	1.4 (1.2-1.6)	1.0 (1.0-1.0)
-1	1109	10 873	11	(7-17)	12.7 (12.5-13.0)	7	(3-13)	9.4 (9.3-9.4)	1	1.5 (1.4-1.6)	1.1 (1.0-1.1)
1	1109	10 873	11	(6-18)	13.5 (13.3-13.7)	7	(3-13)	9.7 (9.6-9.7)	1	1.8 (1.7-2.0)	1.2 (1.2-1.2)
2	1080	10 499	10	(5-16)	13.3 (13.0-13.5)	7	(3-13)	10.5 (10.5-10.6)	1	1.8 (1.6-1.9)	1.3 (1.2-1.3)
3	883	8612	10	(5-16)	13.1 (12.9-13.4)	7	(3-14)	10.7 (10.6-10.8)	1	2.0 (1.8-2.2)	1.4 (1.3-1.4)
4	685	6748	9	(5-15)	13.5 (13.2-13.8)	7	(3-13)	11.2 (11.1-11.3)	1	2.0 (1.8-2.3)	1.4 (1.3-1.5)
5	465	4766	10	(5-15)	13.6 (13.2-13.9)	8	(3-14)	11.7 (11.6-11.8)	1	2.3 (2.0-2.6)	1.5 (1.4-1.5)
6	317	3259	9	(5-14)	13.8 (13.4-14.3)	8	(3-14)	12.3 (12.2-12.5)	1	2.2 (1.8-2.6)	1.4 (1.4-1.5)
7	189	1998	9	(4-15)	15.5 (14.9-16.2)	8	(3-14)	13.2 (13.0-13.4)	1	2.3 (1.9-2.9)	1.5 (1.4-1.6)
8	83	927	10	(6-14)	23.7 (22.3-25.3)	8	(3-14)	21.4 (21.0-21.8)	1	3.5 (2.4-5.0)	1.8 (1.5-2.2)
Treatments/examinations											
Year relative to index	Persons at-risk, n		Outpatient visits			ED visits			PV		
	PV	non-PV	PV	Median (IQR) ^a	Mean (95% CI) ^b	PV	Median (IQR) ^a	Mean (95% CI) ^b	PV	Median (IQR) ^a	Mean (95% CI) ^b
-2	1109	10 873	2	(1-4)	3.4 (3.2-3.5)	2	(1-3)	2.9 (2.9-3.0)	1	1.3 (1.1-1.5)	0.7 (0.7-0.7)
-1	1109	10 873	3	(2-6)	4.5 (4.4-4.7)	2	(1-4)	3.5 (3.5-3.6)	1	1.4 (1.3-1.6)	0.7 (0.7-0.8)
1	1109	10 873	12	(7-17)	13.0 (12.8-13.3)	2	(1-4)	3.8 (3.8-3.9)	1	1.5 (1.3-1.7)	0.8 (0.8-0.9)
2	1080	10 499	6	(3-10)	7.9 (7.7-8.1)	2	(1-4)	3.8 (3.8-3.9)	1	1.5 (1.3-1.6)	0.8 (0.8-0.9)
3	883	8612	5	(2-9)	7.0 (6.8-7.2)	2	(1-4)	3.9 (3.8-3.9)	1	1.6 (1.4-1.9)	1.0 (0.9-1.0)

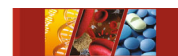


TABLE 3 (Continued)

Year relative to index	Persons at-risk, n		Outpatient visits			ED visits			Treatments/examinations		
	PV	nonPV	PV	nonPV	PV	PV	nonPV	PV	PV	nonPV	nonPV
	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b
4	685	6748	5 (2-8)	7.0 (6.8-7.3)	2 (1-4)	1 (1-2)	1.5 (1.3-1.8)	1 (0-1)	6 (3-12)	2 (1-6)	6.3 (6.2-6.4)
5	465	4766	4 (2-8)	7.4 (7.1-7.8)	2 (1-4)	1 (1-2)	4.0 (3.9-4.1)	1 (0-1)	6 (3-12)	2 (1-6)	6.7 (6.6-6.8)
6	317	3259	4 (2-8)	8.2 (7.7-8.6)	2 (1-4)	1 (1-2)	4.0 (3.9-4.1)	1 (0-1)	6 (3-12)	2 (1-6)	6.5 (6.4-6.7)
7	189	1998	3 (2-6)	8.7 (8.1-9.3)	2 (1-4)	1 (1-1)	3.6 (3.4-3.7)	1 (0-1)	5 (2-11)	2 (1-6)	6.3 (6.1-6.4)
8	83	927	3 (1-6)	9.8 (8.6-11.2)	1 (1-3)	1 (1-2)	3.7 (3.4-4.0)	1 (0-1)	5 (1-10)	2 (1-4)	6.2 (5.8-6.5)

^aMedian healthcare resource utilization was defined by the median number of contacts, episodes, days, visits, or treatments/examinations per person at risk in the cohort on January 1 of the respective year.

^bMean healthcare intensity was calculated as number of contacts, episodes, days, visits, or treatments/examinations divided by person-years at risk (each individual provided person-time to every year until date of a censoring event).

ET patients versus *nonET* comparisons

During the years after diagnosis, ET patients had a higher annual median HRU than *nonET* comparisons regarding GP contacts, inpatient days, outpatient visits, as well as treatments/examinations (Table 2). The median number of GP contacts (11 [IQR: 5-18]), outpatient visits (9 [IQR: 5-13]), and treatments/examinations (10 [IQR: 5-16]) peaked in the first year post-diagnosis. Accordingly, we observed higher intensity of HRU among ET patients than among their comparisons regarding all types of HRU, corresponding to RRs varying from 2.7 (95% CI: 2.6-2.9) for outpatient visits in the first year post-diagnosis down to 1.0 (95% CI: 0.8-1.3) for outpatient visits in the eighth year post-diagnosis (Figure 1 and Table S3).

PV patients versus *nonPV* comparisons

In all years of follow-up, PV patients had a higher median number of GP contacts, inpatient days, outpatient visits, and treatments/examinations than their comparisons (Table 3). In PV patients, the median number of outpatient visits (12 [IQR: 7-17]) and treatments/examinations (16 [IQR: 9-23]) peaked in the first year of follow-up. In contrast, the median number of inpatient days increased during follow-up from 3 days (IQR: 1-8) in the first year post-diagnosis to 9 days (IQR: 2-35) in the eighth year, while remaining stable at 1-2 days in *nonPV* comparisons. The largest differences in the intensity of HRU between PV and *nonPV* were observed in the last year of follow-up for most types of HRU: hospitalizations (RR = 1.9 [95% CI: 1.5-2.4]), inpatient days (RR = 3.8 [95% CI: 3.0-4.8]), ED visits (RR = 2.0 [95% CI: 1.6-2.5]), and treatments/examinations (RR = 3.3 [95% CI: 2.7-4.2]) (Figure 1 and Table S3).

MF patients versus *nonMF* comparisons

MF patients had a higher median number than *nonMF* comparisons regarding hospitalizations, inpatient days, outpatient visits, and treatments/examinations (Table 4). In MF patients, the median number of outpatient visits (13 [IQR: 8-20]) and treatments/examinations (17 [IQR: 10-32]) was particularly high in the first year of follow-up. For MF patients, the median number of inpatient days peaked with 12 days (IQR: 7-27) in the sixth year post-diagnosis, while it remained at 2-3 days in *nonMF* comparisons. Correspondingly, we observed a first peak in RR for both GP contacts (1.4 [95% CI: 1.3-1.6]) and hospital-related HRU types, including ED visits (1.8 [95% CI: 1.6-1.9]) in the first year after MPN diagnosis (Figure 1 and Table S3). This was followed by a second peak in all types of hospital contacts in the sixth year post-diagnosis with RRs ranging from 1.8 (95% CI: 1.5-2.1) for ED visits to 2.9 (95% CI: 2.4-3.6) for inpatient days.

MPN-U patients versus *nonMPN-U* comparisons

In line with the findings in the other MPN subtypes, patients registered with MPN-U had a higher median number of GP contacts, inpatient days, outpatient visits, and treatments/examinations than *nonMPN-U* comparisons (Table 5). In addition, a peak in median HRU was seen in MPN-U in the first year following diagnosis regarding GP contacts (13 [IQR: 7-21]), outpatient visits (10 [IQR: 5-16]), and treatments/examinations (14 [IQR: 6-26]). The largest discrepancies in the



TABLE 4 Healthcare resource utilization in MF patients and non-MF comparisons pre- and post-diagnosis

Year relative to index	Persons at-risk, n		GP contacts			Hospitalizations			Inpatient days		
	MF	non-MF	MF		non-MF	MF		non-MF	MF		non-MF
			Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a
-2	533	5217	9 (4-14)	10.5 (10.2-10.8)	7 (3-14)	1 (1-2)	1.7 (1.4-1.9)	1 (0-1)	4 (1-11)	7.8 (7.3-8.4)	1 (0-6)
-1	533	5217	12 (7-19)	14.0 (13.7-14.4)	8 (3-14)	1 (1-2)	1.8 (1.6-2.0)	1 (0-2)	6 (2-16)	11.5 (11.1-11.9)	1 (0-7)
1	533	5217	11 (6-19)	15.0 (14.7-15.4)	8 (4-14)	2 (1-4)	3.2 (3.0-3.4)	1 (1-2)	7 (2-24)	20.2 (19.6-20.7)	2 (1-8)
2	462	4990	10 (5-17)	14.5 (14.2-14.9)	8 (4-14)	2 (1-3)	3.3 (3.0-3.6)	1 (0-2)	9 (2-22)	21.4 (20.7-22.1)	2 (0-8)
3	338	4107	10 (4-17)	14.1 (13.6-14.5)	8 (4-15)	2 (1-3)	2.8 (2.5-3.1)	1 (1-2)	6 (2-15)	13.4 (12.7-14.1)	2 (1-9)
4	249	3236	10 (4-18)	14.3 (13.8-14.8)	8 (4-15)	2 (1-3)	2.6 (2.3-3.0)	1 (1-2)	5 (1-14)	12.1 (11.4-12.8)	2 (1-8)
5	184	2545	9 (5-17)	15.0 (14.4-15.6)	8 (4-15)	2 (1-2)	2.5 (2.1-3.0)	1 (1-2)	5 (1-14)	13.7 (12.7-14.7)	2 (1-9)
6	114	1688	8 (3-15)	15.8 (14.9-16.7)	9 (4-16)	2 (1-4)	4.0 (3.1-5.0)	1 (1-2)	12 (7-27)	28.0 (25.7-30.6)	3 (1-10)
7	51	995	9 (5-15)	16.1 (14.8-17.5)	9 (4-15)	2 (1-3)	2.4 (1.6-3.4)	1 (1-2)	5 (1-13)	8.6 (7.1-10.4)	3 (1-8)
8	26	434	12 (6-23)	30.4 (27.6-33.4)	10 (4-16)	2 (1-2)	2.4 (0.9-5.2)	1 (1-1)	4 (2-18)	15.6 (11.1-21.4)	2 (1-7)
Treatments/examinations											
Year relative to index	Persons at-risk, n		Outpatient visits			ED visits			MF		
	MF	non-MF	MF		non-MF	MF		non-MF	MF		non-MF
			Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a
-2	533	5217	2 (1-5)	4.5 (4.3-4.8)	2 (1-4)	1 (1-1)	3.2 (3.1-3.3)	1 (0-1)	3 (2-7)	7.1 (6.8-7.4)	2 (1-6)
-1	533	5217	4 (2-7)	6.3 (6.0-6.5)	2 (1-5)	1 (1-1)	4.1 (4.0-4.1)	1 (0-1)	6 (2-11)	9.3 (9.0-9.5)	3 (1-7)
1	533	5217	13 (8-20)	17.0 (16.6-17.3)	2 (1-5)	1 (1-2)	4.2 (4.2-4.3)	1 (0-1)	17 (10-32)	26.9 (26.4-27.3)	3 (1-7)
2	462	4990	7 (4-12)	12.2 (11.8-12.6)	2 (1-5)	1 (1-2)	4.1 (4.0-4.2)	1 (0-1)	10 (5-23)	20.5 (20.0-21.0)	3 (1-6)
3	338	4107	6 (3-12)	9.8 (9.4-10.2)	2 (1-5)	1 (1-2)	4.4 (4.3-4.5)	1 (0-1)	8 (4-19)	16.1 (15.6-16.6)	3 (1-7)

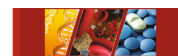


TABLE 4 (Continued)

Year relative to index	Persons at-risk, n		Outpatient visits				ED visits				Treatments/examinations			
	MF	nonMF	MF		nonMF		MF		nonMF		MF		nonMF	
			Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b
4	249	3236	5 (2-11)	9.3 (8.9-9.7)	2 (1-5)	4.3 (4.2-4.4)	1 (1-2)	1.6 (1.2-2.0)	1 (0-1)	1.1 (1.1-1.2)	8 (4-20)	16.1 (15.6-16.7)	3 (1-8)	7.1 (7.0-7.2)
5	184	2545	5 (3-9)	8.5 (8.0-9.0)	2 (1-5)	4.5 (4.4-4.6)	1 (1-2)	1.7 (1.3-2.3)	1 (0-1)	1.3 (1.2-1.4)	8 (4-18)	15.2 (14.5-15.9)	3 (1-7)	7.2 (7.1-7.4)
6	114	1688	4 (2-9)	8.2 (7.5-8.9)	2 (1-5)	4.2 (4.1-4.4)	1 (1-2)	2.5 (1.6-3.7)	1 (1-1)	1.4 (1.3-1.6)	6 (3-17)	18.0 (17.0-19.1)	3 (1-8)	6.9 (6.7-7.1)
7	51	995	4 (1-6)	5.6 (4.7-6.6)	2 (1-4)	3.7 (3.5-3.9)	2 (1-4)	2.3 (1.2-3.9)	1 (1-2)	1.7 (1.5-1.9)	5 (2-15)	12.0 (10.7-13.4)	2 (1-6)	7.0 (6.7-7.2)
8	26	434	2 (1-4)	5.4 (3.9-7.2)	2 (1-3)	4.8 (4.4-5.3)	1 (1-2)	2.2 (0.9-4.6)	1 (1-1)	1.7 (1.3-2.2)	3 (2-6)	11.2 (9.2-13.5)	2 (1-5)	7.4 (6.8-7.9)

^aMedian healthcare resource utilization was defined by the median number of contacts, episodes, days, visits, or treatments/examinations per person at risk in the cohort on January 1 of the respective year.

^bMean healthcare intensity was calculated as number of contacts, episodes, days, visits, or treatments/examinations divided by person-years at risk (each individual provided person-time to every year until date of a censoring event).

intensity of HRU between MPN-U and nonMPN-U were observed for inpatient days (RR = 3.1 [95% CI: 2.8-3.4]) in the year preceding diagnosis; and for GP contacts (RR = 1.5 [95% CI: 1.4-1.7]), outpatient visits (RR = 3.7 [95% CI: 3.4-4.0]), ED visits (RR = 2.1 [95% CI: 1.9-2.3]), and treatments/examinations (RR = 3.8 [95% CI: 3.5-4.1]) in the first year following diagnosis (Figure 1 and Table S3).

4 | DISCUSSION

This is the first nationwide study to report detailed pre- and post-diagnostic data on HRU in patients with ET, PV, MF, and MPN-U. We found that, compared with matched comparisons, MPN patients had an overall higher HRU throughout the study period regardless of MPN subtype. Interestingly, our study also revealed substantial increases of most HRU measures from 2 years before the MPN diagnosis.

Overall, baseline characteristics of the Danish MPN patients, such as age at diagnosis, male-to-female ratio, and MPN subtype distribution, were comparable with the existing literature.³⁴⁻³⁷ Further, in line with previous findings, Danish MPN patients had higher mortality than the matched comparisons during the study period, which was driven by a more than twofold higher mortality among MF and MPN-U patients relative to their comparisons.^{36,38} Diverging results on mortality of patients with MPN-U exist.^{36,39} In a Norwegian registered-based study,³⁶ standardized mortality rates were substantially elevated in patients with MPN-U (and MF) compared with the background population, thus similar to our study population. Conversely, a newly published retrospective study³⁹ investigating MPN-associated splanchnic vein thromboses, found that patients with MPN-U had a particularly indolent phenotype with low mortality.

When assessing HRU by MPN subtype, several results are worth highlighting. Even though ET is often considered indolent, we still observed that ET patients had an overall higher HRU than the matched nonET individuals throughout our study, which is in accordance with previous results.^{18,19} Interestingly, we found that the intensity of outpatient visits and hospital treatments/examinations was highest in the first year after diagnosis. In line with our findings, Bankar et al. also reported the highest HRU around the time of diagnosis.¹⁹ The high HRU in the first year after diagnosis is most likely explained by diagnostic work-up and frequent visits during treatment initiation, but it may also reflect attention drawn to comorbidity or complications. For example, Hultcrantz et al. showed a nearly 10-fold elevation in venous thrombosis rate 3 months after diagnosis in MPN patients.^{8,40} We found no major fluctuations in RRs for HRU in the remaining years of follow-up (up to 8 years), which is in agreement with studies reporting that ET progression often occurs beyond the first decade post-diagnosis.⁴¹

In line with the existing literature, PV patients constituted a larger HRU burden than nonPV individuals in all years of follow-up.^{18,19} Noteworthy, the increase in RRs for outpatient visits and treatments/examinations within the first year after diagnosis was even more pronounced for PV than for ET. This likely reflects the initial requirement of frequent phlebotomies, in addition to diagnostic work-up and initiation of cytoreductive therapy. Given the higher average age in PV



TABLE 5 Healthcare resource utilization in MPN-U patients and non-MPN-U comparisons pre- and post-diagnosis

Year relative to index	Persons at-risk, <i>n</i>		GP contacts		Hospitalizations				Inpatient days					
	MPN-U	non-MPN-U	MPN-U		non-MPN-U		MPN-U		non-MPN-U		MPN-U		non-MPN-U	
			Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b
-2	560	5466	9 (4-16)	11.3 (11.0-11.5)	7 (3-13)	9.4 (9.3-9.5)	1 (1-2)	1.7 (1.5-2.0)	1 (0-1)	1.0 (1.0-1.1)	5 (1-10)	8.5 (8.0-9.0)	1 (0-5)	4.9 (4.8-5.1)
-1	560	5466	13 (8-20)	14.9 (14.5-15.2)	8 (3-14)	10.0 (9.9-10.1)	1 (1-2)	1.8 (1.6-2.0)	1 (0-1)	1.1 (1.1-1.2)	8 (2-18)	15.9 (15.5-16.5)	1 (0-5)	5.1 (5.0-5.3)
1	560	5466	13 (7-21)	15.5 (15.2-15.9)	8 (3-14)	10.2 (10.1-10.3)	1 (1-3)	2.6 (2.4-2.8)	1 (0-2)	1.3 (1.2-1.3)	6 (2-21)	16.9 (16.4-17.5)	1 (0-7)	6.2 (6.1-6.4)
2	504	5265	11 (6-19)	15.5 (15.1-15.8)	8 (3-14)	11.1 (11.0-11.2)	1 (1-3)	2.6 (2.4-2.9)	1 (0-2)	1.3 (1.3-1.4)	6 (1-17)	13.8 (13.2-14.4)	1 (0-6)	6.1 (6.0-6.3)
3	377	4189	10 (6-18)	15.4 (15.0-15.8)	8 (3-14)	11.7 (11.6-11.8)	2 (1-3)	3.2 (2.9-3.6)	1 (0-2)	1.5 (1.4-1.5)	8 (2-17)	16.2 (15.5-17.1)	1 (0-7)	6.9 (6.8-7.1)
4	268	3284	9 (5-16)	14.2 (13.7-14.7)	8 (3-14)	11.8 (11.7-11.9)	1 (1-3)	2.8 (2.4-3.3)	1 (1-2)	1.5 (1.4-1.6)	7 (1-16)	16.1 (15.1-17.1)	2 (0-8)	7.3 (7.1-7.6)
5	185	2447	10 (5-18)	14.6 (14.0-15.2)	8 (4-14)	11.7 (11.5-11.8)	2 (1-2)	2.2 (1.8-2.7)	1 (1-1)	1.4 (1.3-1.5)	9 (2-16)	14.3 (13.1-15.5)	2 (1-7)	6.2 (6.0-6.5)
6	130	1788	11 (5-17)	15.8 (15.1-16.6)	8 (3-14)	12.7 (12.5-12.8)	1 (1-2)	2.0 (1.5-2.7)	1 (1-2)	1.5 (1.4-1.7)	2 (1-8)	8.8 (7.7-10.0)	2 (1-7)	7.1 (6.8-7.4)
7	73	1137	10 (6-15)	16.8 (15.7-17.9)	8 (3-14)	13.2 (12.9-13.4)	1 (1-2)	2.5 (1.8-3.4)	1 (1-2)	1.6 (1.4-1.8)	1 (1-7)	7.8 (6.5-9.3)	2 (1-6)	6.1 (5.7-6.4)
8	30	508	9 (6-15)	23.2 (20.9-25.7)	8 (3-14)	19.0 (18.4-19.5)	2 (1-2)	3.4 (1.1-8.0)	1 (1-1)	1.8 (1.4-2.2)	11 (1-13)	17.1 (11.1-25.3)	1 (1-5)	6.6 (5.9-7.4)
Persons at-risk, <i>n</i>			Outpatient visits			ED visits			Treatments/examinations					
Year relative to index	MPN-U	non-MPN-U	MPN-U		non-MPN-U		MPN-U		non-MPN-U		MPN-U		non-MPN-U	
			Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b
	-2	560	5466	2 (1-5)	3.8 (3.6-4.0)	2 (1-4)	2.9 (2.8-2.9)	1 (1-2)	1.3 (1.1-1.6)	1 (0-1)	0.7 (0.7-0.8)	3 (1-7)	7.1 (6.8-7.4)	2 (1-5)
-1	560	5466	3 (2-7)	5.5 (5.3-5.7)	2 (1-4)	3.5 (3.4-3.6)	1 (1-2)	1.4 (1.2-1.7)	1 (0-1)	0.8 (0.7-0.8)	5 (2-11)	10.1 (9.8-10.4)	2 (1-6)	5.4 (5.3-5.5)
1	560	5466	10 (5-16)	13.6 (13.3-13.9)	2 (1-4)	3.7 (3.6-3.8)	1 (1-2)	1.8 (1.5-2.0)	1 (0-1)	0.8 (0.8-0.9)	14 (6-26)	23.1 (22.7-23.5)	2 (1-7)	6.1 (6.0-6.2)
2	504	5265	5 (2-10)	9.0 (8.7-9.4)	2 (1-4)	3.9 (3.8-4.0)	1 (1-2)	1.7 (1.4-1.9)	1 (0-1)	1.0 (0.9-1.0)	8 (3-16)	15.0 (14.6-15.4)	2 (1-7)	6.4 (6.3-6.5)
3	377	4189	4 (2-9)	8.2 (7.9-8.6)	2 (1-4)	3.8 (3.7-3.9)	1 (1-2)	1.9 (1.6-2.3)	1 (0-1)	1.0 (0.9-1.1)	7 (3-16)	14.4 (14.0-14.9)	2 (1-7)	6.4 (6.3-6.5)

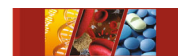


TABLE 5 (Continued)

Year relative to index	Persons at-risk, n		Outpatient visits				ED visits				Treatments/examinations			
	MPN-U	non-MPN-U	MPN-U		non-MPN-U		MPN-U		non-MPN-U		MPN-U		non-MPN-U	
			Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b	Median (IQR) ^a	Mean (95% CI) ^b
4	268	3284	4 (2-9)	7.9 (7.5-8.4)	2 (1-4)	3.9 (3.8-4.0)	1 (1-2)	2.1 (1.6-2.7)	1 (0-1)	1.1 (1.0-1.2)	7 (3-17)	14.1 (13.6-14.7)	3 (1-7)	6.6 (6.5-6.7)
5	185	2447	4 (2-9)	7.0 (6.5-7.5)	2 (1-4)	3.8 (3.7-4.0)	1 (1-1)	1.5 (1.1-2.0)	1 (0-1)	1.1 (1.0-1.2)	6 (2-13)	11.7 (11.0-12.3)	3 (1-6)	6.3 (6.2-6.5)
6	130	1788	3 (1-7)	7.0 (6.4-7.8)	2 (1-4)	4.4 (4.2-4.5)	1 (1-1)	1.5 (0.9-2.3)	1 (0-1)	1.2 (1.1-1.4)	6 (2-9)	10.4 (9.6-11.2)	3 (1-7)	7.2 (7.0-7.4)
7	73	1137	2 (1-6)	5.9 (5.1-6.8)	2 (1-4)	4.2 (4.0-4.4)	1 (1-2)	2.6 (1.8-3.8)	1 (0-1)	1.3 (1.1-1.5)	3 (2-8)	10.3 (9.3-11.4)	3 (1-6)	6.7 (6.5-6.9)
8	30	508	3 (1-5)	4.9 (3.5-6.8)	1 (1-3)	3.5 (3.2-3.9)	1 (1-1)	2.5 (0.7-6.3)	1 (0-1)	1.6 (1.2-2.1)	5 (3-7)	11.8 (9.4-14.5)	2 (1-4)	6.0 (5.6-6.4)

^aMedian healthcare resource utilization was defined by the median number of contacts, episodes, days, visits, or treatments/examinations per person at risk in the cohort on January 1 of the respective year.

^bMean healthcare intensity was calculated as number of contacts, episodes, days, visits, or treatments/examinations divided by person-years at risk (each individual provided person-time to every year until date of a censoring event).

patients, differences in comorbidity may also in part explain this. In contrast to the nearly constant RRs between ET patients and nonET comparisons during the subsequent years of follow-up, the discrepancy in HRU between PV and nonPV comparisons increased noticeably from the first to the eighth year after diagnosis. In particular, high RRs of inpatient days and treatments/examinations were present in the last year of follow-up. This increased difference in HRU between PV patients and nonPV comparisons toward the end of follow-up could reflect progression of PV and PV-associated comorbidity. However, cautious interpretation is necessary, as numbers were small and confidence intervals wide. Also important to notice is the considerably higher mean HRU intensity than median HRU, especially in the later years of follow-up. Such skewed distributions are common for HRU data and illustrate that a subgroup of patients have substantially higher HRU than the majority of patients.⁴² In our study, this subgroup might represent patients with particularly debilitating symptoms, refractory disease, or transformation to acute myeloid leukemia. In addition, previous studies have shown that HRU is significantly higher in PV patients who encounter a thromboembolic event.^{43,44}

We found the most marked differences in HRU between MF patients and nonMF comparisons, which substantiates previous findings.^{2,4,45} Interestingly, the HRU of MF patients displayed a different pattern from the HRU of ET and PV patients, displaying a second peak in RRs of hospital-related HRU in the sixth year of follow-up. Especially, the intensity of inpatient days among MF patients was significantly higher than among nonMF comparisons. Conversely, much lower RRs for HRU were found in the last 2 years of follow-up. Given the poor prognosis of MF, the declined HRU in these years is probably a consequence of a longer survival in MF patients with low HRU, for example, patients with prefibrotic myelofibrosis categorized as MF before the prefibrotic myelofibrosis diagnosis was introduced (2016). Besides the substantial HRU of MF patients, a Spanish study indicated that MF entails considerable indirect and non-medical costs (e.g., lost productivity and informal care).⁴⁶

Another novel finding from the present study was that MPN-U patients had a substantially higher HRU than nonMPN-U comparisons. MPN-U is a heterogeneous entity including a wide spectrum of patients. At one end patients not yet fulfilling the diagnostic criteria for ET, PV, and MF and at the other end patients with advanced stage MPN with pronounced fibrosis and increased blasts.⁴⁷ The observed high mortality of MPN-U patients in our study indicates that the MPN-U population in Denmark (overall) represents relatively advanced-stage MPN, which is in line with a Danish nationwide questionnaire study,⁴⁸ reporting that patients with MPN-U had the worst health-related quality of life of the MPN subtypes.

In most years of follow-up, MPN patients had more registered GP contacts than their comparisons. Compared with the existing literature, MPN patients in our study had more GP contacts than outpatient visits, whereas Bankar et al. found that outpatient care was equally divided between GPs and outpatient specialists (hematologist or oncologist) for ET and PV, while MF was more often seen by an outpatient specialist.¹⁹ In our study, GP contacts included telephone and email consultations, while outpatient consultations only included visits, which may contribute to the observed difference.

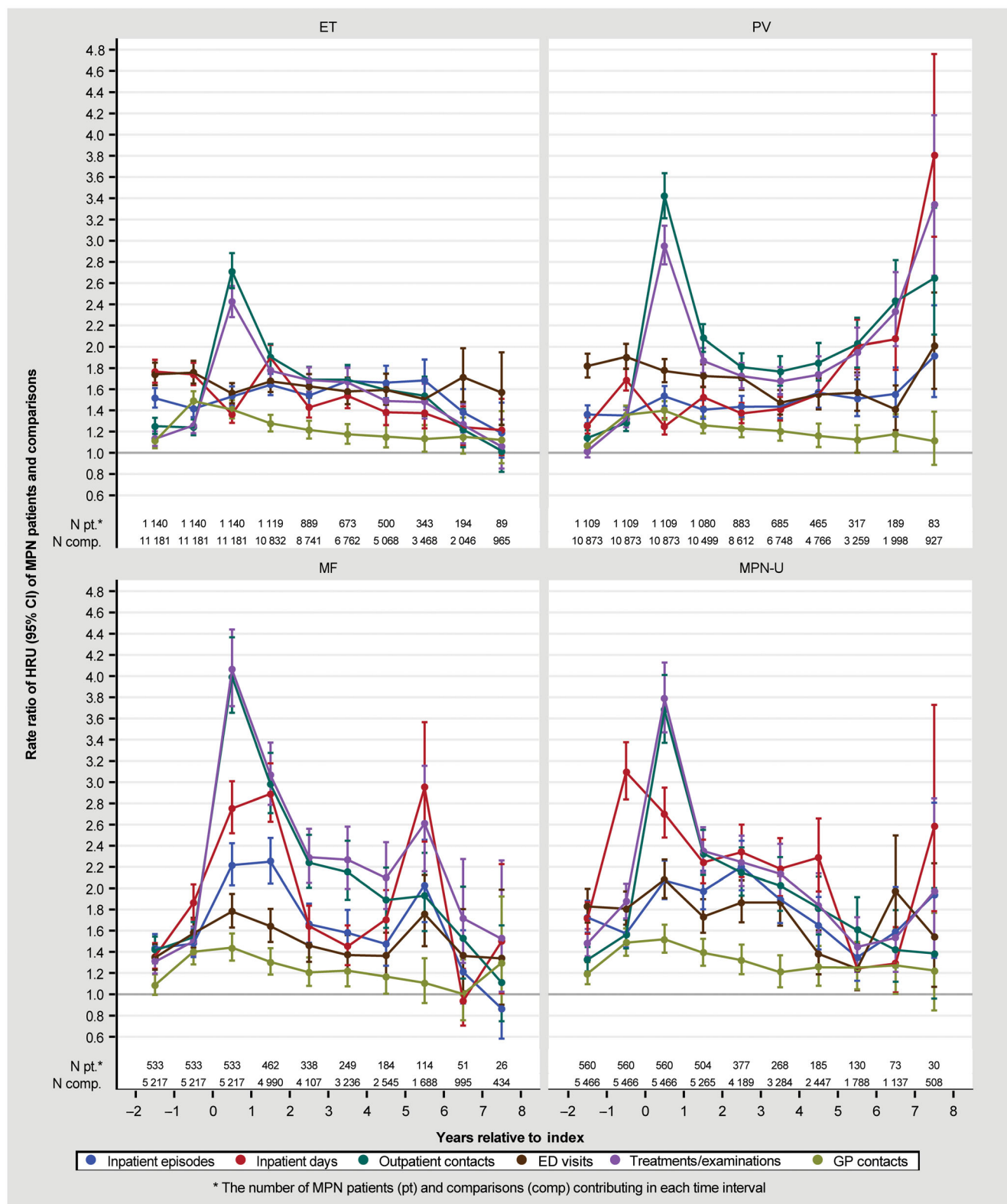
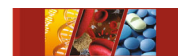


FIGURE 1 Rate ratios of healthcare resource utilization between ET, PV, MF, and MPN-U patients and their comparisons. comp, comparisons; ET, essential thrombocythemia; HRU, healthcare resource utilization; MPN, myeloproliferative neoplasms; MPN-U, unclassifiable myeloproliferative neoplasm; MF, myelofibrosis; pt, patients; PV, polycythemia vera

Of note, irrespective of MPN subtype, MPN patients were more often seen in the ED than non-MPN comparisons. In the study by Mehta et al., MPN patients also accounted for more ED visits than the

matched comparisons.¹⁸ The additional ED visits in MPN patients may represent acute MPN complications and side effects of MPN treatment.^{5,7,8,11,13}



Assessing the pre-diagnostic period, MPN patients had a higher intensity of HRU than matched comparisons across HRU measures. For nearly all types of HRU, these differences were further augmented in the last year prior to diagnosis, possibly reflecting intensified diagnostic work-up. Interestingly, the highest RRs in the pre-diagnostic period were observed for inpatients days and ED visits, which might suggest that quite severe MPN manifestations, or MPN-associated comorbidity, are detectable at least 2 years before diagnosis. In support of these speculations, MPN patients have been found to have higher comorbidity than the background population before time of diagnosis,¹⁹ which is in accordance with the baseline CCI scores found in the present study. The increased pre-diagnostic HRU was expected based on recent studies indicating that MPNs are often diagnosed months, or even years, after the first signs of MPN. For example, in the US Landmark Study, approximately half of the patients reported MPN-related symptoms ≥ 1 year before the diagnosis.⁴⁹ Further, a retrospective MPN study by Enblom et al. found that 66% of the vascular complications occurred during the 2 years preceding MPN diagnosis, and that blood test results frequently fulfilled the diagnostic criteria for MPN several months preceding diagnosis.²¹ Lastly, a recent Danish screening study of cytosis and MPN driver mutations in the general population raised concerns about potential under-diagnosis of MPNs.²⁰

Certain study limitations must be taken into consideration; First, despite a nationwide setting, limitations include small numbers toward the end of follow-up, as MPNs are rare diseases with an overall reduced survival. Moreover, patients diagnosed in the last part of the inclusion period did not have many years of follow-up. Second, misclassification within the MPN subtypes cannot be ruled out, as accurate classification can be difficult. However, in Denmark, all patients suspected of having a hematological disease are referred to hematology departments with equal access to diagnostic work-up like mutational analysis and bone marrow biopsy, which improves the diagnostic certainty. Third, the Danish National Health Service Registry has not yet been validated, but it does have an assumed high coverage as data collection is related to reimbursements of the GPs.³³ Fourth, we could not distinguish between HRU related to MPN and to comorbidity. However, as MPN patients had an increased comorbidity burden at baseline it is likely that comorbidity contributed to their augmented HRU. Finally, the matching of MPN patients and non-MPN comparisons might not have been balanced in the last years of follow-up due to longer survival of comparisons than patients.

A major strength of our study was the matched comparison design and the high quality of the Danish registries. Since 2010, it has been mandatory to report all newly diagnosed MPN patients to the DCMR. To ensure that no MPN patients are lost to follow-up, these reports are cross-merged with the DNPR.²⁴ This thorough registration, along with the nationwide design, diminishes selection bias. Another strength was the unambiguous linkage of data combined with the universal tax-funded healthcare system, ensuring close to complete data retrieval across healthcare sectors and accurate long-term follow-up. Finally, taking the demographic development⁵⁰ and the fact that MPNs, primarily, are cancers of the elderly into consideration, such HRU analyses are increasingly important for healthcare planning.

In conclusion, patients with MPN had a higher HRU than matched individuals without MPN. This was consistent across all MPN subtypes as well as different HRU measures. Our findings confirm a consistent HRU burden after the MPN diagnosis. Equally important, our study revealed substantially increased HRU in both the primary and secondary sectors 2 years before MPN diagnosis, warranting further exploration of the pre-diagnostic period, including the potential benefits of early detection.

AUTHOR CONTRIBUTIONS

Authors who contributed to the conceptualization, study design and/or protocol were Hans Carl Hasselbalch, Marie Bak, Henrik Frederiksen, Sarah Friis Christensen, Christian Fynbo Christiansen, Ellen Margrethe Mikkelsen, Lise Skovgaard Svingel, Björn Paulsson, and Anna Stenling. Data were analyzed and summarized by Anders Kjærsgaard, Bianka Darvalics, Ellen Margrethe Mikkelsen, Lise Skovgaard Svingel, whereas Hans Carl Hasselbalch, Henrik Frederiksen, Christen Lykkegaard Andersen, Jesper Stentoft, Mette Borg Clausen, Jørn Starklint, Marianne Tang Severinsen, and Morten Hagemann Hilsøe have contributed to data collection in DCMR. While the paper was written by Sarah Friis Christensen and Lise Skovgaard Svingel, the larger group of Christian Fynbo Christiansen, Anders Kjærsgaard, Bianka Darvalics, Ellen Margrethe Mikkelsen, Hans Carl Hasselbalch, Marie Bak, Henrik Frederiksen, Christen Lykkegaard Andersen, Jesper Stentoft, Mette Borg Clausen, Jørn Starklint, Marianne Tang Severinsen, Morten Hagemann Hilsøe, Anna Stenling, and Björn Paulsson have all actively contributed to the interpretation of the results and the revisions of the manuscript. All authors approved of the final version and are accountable for ensuring accuracy and integrity of the work.

ACKNOWLEDGMENTS

The authors would like to thank the Danish hematologists for their continued efforts in reporting MPN data to the DCMR. Moreover, we thank Professor Henrik Toft Sørensen for participating in planning the study.

CONFLICT OF INTEREST

Novartis funded the work done by the employees at Aarhus University. Anders Kjærsgaard, Bianka Darvalics, Christian Fynbo Christiansen, Ellen Margrethe Mikkelsen, and Lise Skovgaard Svingel: employees at Aarhus University. Anna Stenling and Björn Paulsson: employees at Novartis. Hans Carl Hasselbalch: consultant for Novartis. All authors declare no personal competing interests.

DATA AVAILABILITY STATEMENT

Individual patient data will not be shared.

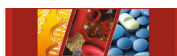
ORCID

Sarah Friis Christensen <https://orcid.org/0000-0003-2178-0440>

Lise Skovgaard Svingel <https://orcid.org/0000-0002-4938-037X>

Marianne Tang Severinsen <https://orcid.org/0000-0003-0996-1812>

Hans Carl Hasselbalch <https://orcid.org/0000-0003-3936-8032>

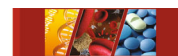


Henrik Frederiksen  <https://orcid.org/0000-0001-8905-0220>

Marie Bak  <https://orcid.org/0000-0002-1511-6749>

REFERENCES

- Arber DA, Orazi A, Hasserjian R, et al. The 2016 revision to the World Health Organization classification of myeloid neoplasms and acute leukemia. *Blood*. 2016;127(20):2391-2406.
- Nangalia J, Green AR. Myeloproliferative neoplasms: from origins to outcomes. *Blood*. 2017;130(23):2475-2483.
- Geyer HL, Dueck AC, Scherber RM, Mesa RA. Impact of inflammation on myeloproliferative neoplasm symptom development. *Mediators Inflamm* [Internet]. 2015;284706. [10.1155/2015/284706](https://doi.org/10.1155/2015/284706)
- Spivak JL. Myeloproliferative neoplasms. *N Engl J Med*. 2017;4:2168-2181.
- Landtblom AR, Andersson TM-L, Dickman PW, Smedby KE, Eloranta S, Batyrbekova N, Samuelsson J, Björkholm M, Hultcrantz M. Risk of infections in patients with myeloproliferative neoplasms—a population-based cohort study of 8363 patients. *Leukemia* [Internet]. 2021;35(2):476–84. [10.1038/s41375-020-0909-7](https://doi.org/10.1038/s41375-020-0909-7)
- Hasselbalch HC, Bjørn ME. MPNs as inflammatory diseases: the evidence, consequences, and perspectives. *Mediators Inflamm*. 2015;2015:1-16.
- Bak M, Jess T, Flachs EM, Zwisler A-D, Juel K, Frederiksen H. Risk of inflammatory bowel disease in patients with chronic myeloproliferative neoplasms: a nationwide cohort study. *Cancers (Basel)*. 2020;8(12):1-14.
- Frederiksen H, Szépligeti S, Bak M, Ghanima W, Hasselbalch HC, Christiansen CF. Vascular diseases in patients with chronic myeloproliferative neoplasms—impact of comorbidity. *Clin Epidemiol*. 2019;11:955-967.
- Frederiksen H, Farkas DK, Christiansen CF, Hasselbalch HC, Sørensen HT. Chronic myeloproliferative neoplasms and subsequent cancer risk: a Danish population-based cohort study. *Blood*. 2011;118(25):6515-6520.
- Christensen AS, Møller JB, Hasselbalch HC. Chronic kidney disease in patients with the Philadelphia-negative chronic myeloproliferative neoplasms. *Leuk Res* [Internet]. 2014;38(4):490-495. [10.1016/j.leukres.2014.01.014](https://doi.org/10.1016/j.leukres.2014.01.014)
- Landtblom AR, Bower H, Andersson TML, et al. Second malignancies in patients with myeloproliferative neoplasms: a population-based cohort study of 9379 patients. *Leukemia* [Internet]. 2018;32(10):2203-2210. [10.1038/s41375-018-0027-y](https://doi.org/10.1038/s41375-018-0027-y)
- Barbui T, Ghirardi A, Masciulli A, et al. Second cancer in Philadelphia negative myeloproliferative neoplasms (MPN-K). A nested case-control study. *Leukemia*. 2019;33(8):1996-2005.
- Bak M, Sørensen TL, Flachs EM, et al. Age-related macular degeneration in patients with chronic myeloproliferative neoplasms. *JAMA Ophthalmol*. 2017;135(8):835-843.
- Frederiksen H, Farkas DK, Christiansen CF, et al. Survival of patients with chronic myeloproliferative neoplasms and new primary cancers: a population-based cohort study. *Lancet Haematol*. 2015;2(7):e289-e296.
- Marchetti M, Ghirardi A, Masciulli A, et al. Second cancers in MPN: survival analysis from an international study. *Am J Hematol*. 2020;95(3):295-301.
- Harrison CN, Mesa RA, Kiladjan JJ, et al. Health-related quality of life and symptoms in patients with myelofibrosis treated with ruxolitinib versus best available therapy. *Br J Haematol*. 2013;162(2):229-239.
- Kröger N. Current challenges in stem cell transplantation in myelofibrosis. *Curr Hematol Malig Rep*. 2015;10(4):344-350.
- Mehta J, Wang H, Fryzek JP, Iqbal SU, Mesa R. Health resource utilization and cost associated with myeloproliferative neoplasms in a large United States health plan. *Leuk Lymphoma*. 2014;55(10):2368-2374.
- Bankar A, Zhao H, Iqbal J, et al. Healthcare resource utilization in myeloproliferative neoplasms: a population-based study from Ontario, Canada. *Leuk Lymphoma* [Internet]. 2020;61(8):1908-1919. [10.1080/10428194.2020.1749607](https://doi.org/10.1080/10428194.2020.1749607)
- Cordua S, Kjaer L, Skov V, Pallisgaard N, Hasselbalch HC, Ellervik C. Prevalence and phenotypes of JAK2 V617F and calreticulin mutations in a Danish general population. *Blood*. 2019;134(5):469-479.
- Enblom A, Lindskog E, Hasselbalch H, et al. High rate of abnormal blood values and vascular complications before diagnosis of myeloproliferative neoplasms. *Eur J Intern Med* [Internet]. 2015;26(5):344-347. [10.1016/j.ejim.2015.03.009](https://doi.org/10.1016/j.ejim.2015.03.009)
- Harrison CN, Koschmieder S, Foltz L, et al. The impact of myeloproliferative neoplasms (MPNs) on patient quality of life and productivity: results from the international MPN landmark survey. *Ann Hematol*. 2017;96(10):1653-1665.
- Schmidt M, Schmidt SAJ, Adelborg K, et al. The Danish health care system and epidemiological research: from health care contacts to database records. *Clin Epidemiol*. 2019;11:563-591.
- Bak M, Ibfelt EH, Larsen TS, et al. The Danish national chronic myeloid neoplasia registry. *Clin Epidemiol*. 2016;8:567-572.
- DSKMS. Dansk Database for Kroniske Myeloproliferative Neoplasier, Årsrapport 2018; 2019.
- DSKMS. Dansk Database for Kroniske Myeloproliferative Neoplasier, Årsrapport 2016; 2016.
- DSKMS. Dansk Database for Kroniske Myeloproliferative Neoplasier, Årsrapport 2013; 2013.
- Schmidt M, Pedersen L, Sørensen HT. The Danish civil registration system as a tool in epidemiology. *Eur J Epidemiol*. 2014;29(8):541-549.
- UDDA. Statistics Denmark [Internet]. Accessed March 27, 2021. [http://www.dst.dk/extranet/ForskningVariabellister/UDDA-Uddannelser\(BUE\).html](http://www.dst.dk/extranet/ForskningVariabellister/UDDA-Uddannelser(BUE).html)
- Petersson F, Baadsgaard M, Thygesen LC. Danish registers on personal labour market affiliation. *Scand J Public Health*. 2011;39(7):95-98.
- Lyng E, Sandegaard JL, Rebolj M. The Danish national patient register. *Scand J Public Health*. 2011;39(7):30-33.
- Schmidt M, Alba S, Schmidt J, et al. The Danish National Patient Registry: a review of content, data quality, and research potential. *Clin Epidemiol* [Internet]. 2015;7:449-490. [10.2147/CLEP.s91125](https://doi.org/10.2147/CLEP.s91125)
- Andersen JS, Olivarius NDF, Krasnik A. The Danish National Health Service Register. *Scand J Public Health*. 2011;39(7):34-37.
- Moulard O, Mehta J, Fryzek J, Olivares R, Iqbal U, Mesa RA. Epidemiology of myelofibrosis, essential thrombocythemia, and polycythemia vera in the European Union. *Eur J Haematol*. 2014;92(4):289-297.
- Shallis RM, Wang R, Davidoff A, Ma X, Podoltsev NA, Zeidan AM. Epidemiology of the classical myeloproliferative neoplasms: the four corners of an expansive and complex map. *Blood Rev* [Internet]. 2020;42(March):100706. [10.1016/j.blre.2020.100706](https://doi.org/10.1016/j.blre.2020.100706)
- Roaldsnes C, Holst R, Frederiksen H, Ghanima W. Myeloproliferative neoplasms: trends in incidence, prevalence and survival in Norway. *Eur J Haematol*. 2017;98(1):85-93.
- Hultcrantz M, Ravn Landtblom A, Andréasson B, et al. Incidence of myeloproliferative neoplasms—trends by subgroup and age in a population-based study in Sweden. *J Intern Med*. 2020;287(4):448-454.
- Cervantes F, Passamonti F, Barosi G. Life expectancy and prognostic factors in the classic BCR/ABL-negative myeloproliferative disorders. *Leukemia*. 2008;22(5):905-914.
- Sant'Antonio E, Guglielmelli P, Pieri L, et al. Splanchnic vein thromboses associated with myeloproliferative neoplasms: an international, retrospective study on 518 cases. *Am J Hematol*. 2020;95(2):156-166.
- Hultcrantz M, Dickman PW, Landgren O, et al. Risk of arterial and venous thrombosis in patients with myeloproliferative neoplasms: a



- population-based cohort study. *Ann Intern Med.* 2018;168(5): 317-325.
41. Wolanskyj AP, Schwager SM, McClure RF, Larson DR, Tefferi A. Essential thrombocythemia beyond the first decade: life expectancy, long-term complication rates, and prognostic factors. *Mayo Clin Proc [Internet]*. 2006;81(2):159-166.
 42. Thompson SG, Barber JA. How should cost data in pragmatic randomised trials be. *BMJ.* 2000;320(April):1197-1200.
 43. Komatsu N, Jun GJ, Yonezu T, Ohashi Y. Real-world, retrospective study evaluating thromboembolic events, associated risk factors, and health-care resource utilization in Japanese patients with polycythemia vera. *Int J Hematol [Internet]*. 2020;112(2):176-184. [10.1007/s12185-020-02887-w](https://doi.org/10.1007/s12185-020-02887-w)
 44. Parasuraman SV, Shi N, Paranagama DC, Bonafede M. Health care costs and thromboembolic events in hydroxyurea-treated patients with polycythemia vera. *J Manag Care Spec Pharm.* 2018;24(1): 47-55.
 45. Byun JM, Kim YJ, Youk T, Yang JJ, Yoo J, Park TS. Real world epidemiology of myeloproliferative neoplasms: a population based study in Korea 2004–2013. *Ann Hematol.* 2017;96(3):373-381.
 46. Gimenez E, Besses C, Boque C, et al. Indirect and non-medical economic burden, quality-of-life, and disabilities of the myelofibrosis disease in Spain. *J Med Econ.* 2014;17(6):435-441.
 47. Iurlo A, Gianelli U, Cattaneo D, Thiele J, Orazi A. Impact of the 2016 revised WHO criteria for myeloproliferative neoplasms, unclassifiable: comparison with the 2008 version. *Am J Hematol.* 2017;92(4): E48-E51.
 48. Brochmann N, Flachs EM, Christensen AI, et al. Health-related quality of life in patients with Philadelphia-negative myeloproliferative neoplasms: a nationwide population-based survey in Denmark. *Cancers (Basel).* 2020;12(12):1-17.
 49. Mesa R, Miller CB, Thyne M, et al. Myeloproliferative neoplasms (MPNs) have a significant impact on patients' overall health and productivity: the MPN landmark survey. *BMC Cancer [Internet]*. 2016; 16(1):1-10. [10.1186/s12885-016-2208-2](https://doi.org/10.1186/s12885-016-2208-2)
 50. WHO. National Institute on Aging. National Institute on Health. U.S. Department of Health and Humans. *Global Health and Aging [Internet]*; 2011. Accessed April 20, 2021. https://www.who.int/ageing/publications/global_health.pdf

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Christensen SF, Svingel LS, Kjærsgaard A, et al. Healthcare resource utilization in patients with myeloproliferative neoplasms: A Danish nationwide matched cohort study. *Eur J Haematol.* 2022;109(5):526-541. doi:[10.1111/ejh.13841](https://doi.org/10.1111/ejh.13841)