SOCIOECONOMIC RELEVANCE OF TREATMENT OF CHRONIC HEART FAILURE STAGE NYHA II WITH CRATAEGUS EXTRACT WS® 1442—A PROSPECTIVE 3-YEAR PHARMACOECONOMIC STUDY

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OBJECTIVES: A prospective 3-year observational study has been conducted from 1999 to 2002 to evaluate the pharmacoeconomics of hawthorn-extract treatment of CHF at stage NYHA II. In a cost-utility-analysis (CUA) hawthorn treatment (crataegus extract WS® 1442 as mono- or add-on-therapy) was compared to any other treatment option. Interim results of the study were presented in 2001 and 2002, now the final results are available. METHODS: Open, non-randomized observational cohort study with matched-pairs evaluation. The first cohort (Hawthorn-Cohort, HC) comprised patients receiving hawthorn-extract therapy of CHF, in the second cohort (Conventional-Cohort, CC) patients with any other treatment were observed. A number of 116 pairs were necessary for evaluation. For measuring HRQL the EuroQoL-5D was used. Matching criteria were demographic factors and clinical diagnosis. The perspective of the German statutory health insurance funds was applied. RESULTS: From 140 study centres 614 patients finished the study (HC: 383; CC: 231). Thereof 153 pairs could be established. Mean direct costs per year for HC and CC amounted to 807€ (median: 511€) and 798€ (median: 525€), respectively (p = 0.905). Cost-driving factor was drug acquisition (median HC: 287€; CC: 280€; p = 0.521). Significantly fewer prescriptions were done in HC for concomitant ACE-inhibitors, diuretics, digitalis, and beta-blockers. The clinical symptoms dyspnea and fatigue in HC were significantly improved in comparison to CC. During 3 years in the HC 0.240 QALYs were gained (CC: 0.234; p = 0.867). Costs per QALY gained amounted to 10,113€ and 10,244€ for HC and CC, respectively. CONCLUSIONS: Hawthorn extract WS® 1442 represents an effective treatment alternative in early stages of CHF: Outcomes and costs are comparable to treatment with ACE-inhibitors, diuretics, digitalis, and/or beta-blockers, which are recommended by international guidelines. The symptoms dyspnea and fatigue, which markedly affect the patients’ daily activities, can be improved with WS® 1442.

MODELING THE ECONOMIC IMPACT OF NEW IMPLANTABLE DEFIBRILLATORS WITH A LONGER LIFETIME

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OBJECTIVES: Vitality 2EL, a new implantable defibrillator (ICD), presents a major advantage: a longer lifetime increasing delay before replacement leading to less reimplantations. This study aims to compare direct medical costs, using this new ICD, Vitality 2EL, versus its main competitors in France. METHODS: The first step was to identify among patients included into EVADEF (French national registry of ICD-implanted patients), 7 homogeneous groups according to age at first implant. Then, within each group, we determined average ages and life expectancies using Deale’s method and data from the French national statistical institute (INSEE). A Markov model was built using DATA Tree age Pro 2004 taking into account complication rates from literature. Direct medical costs were assessed from the French health care payer’s perspective and a 2.5% discount rate was applied. This model was applied to those 7 groups, per single & dual chamber defibrillators (VR & DR), in primary and secondary prevention, and for warranted period (defined by manufacturers) and projected longevity at 15%/50% pacing. RESULTS: The model shows an average cost savings range from 34 to 635€ per patient with Vitality 2EL versus competitors. CONCLUSION: Implanting a longer lifetime ICD is clinically beneficial for patients. Furthermore, we demonstrated that it allows cost savings for health care payers.

ECONOMIC ASSESSMENT OF SWITCHING TO EZETIMIBE CO-ADMINISTERED WITH SIMVASTATIN IN SPAIN FOR A COHORT OF PATIENTS NOT AT GOAL ON ATORVASTATIN MONOTHERAPY

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OBJECTIVE: Assess cost-effectiveness of switching patients to ezetimibe 10 mg (EZ10) co-administration with simvastatin 20 mg (S20) versus an atorvastatin titration strategy (patients are titrated to goal or maximum atorvastatin dose of 80 mg) in CHD and CHD equivalent patients not at goal with atorvastatin 10 mg (A10) monotherapy. Method: Decision-analytic model