warranted to identify steps for increasing treatment effectiveness in these patients.

**INFLUENCE OF DIABETES AND BASELINE ST-SEGMENT CHANGE STATUS ON THE COST-EFFECTIVENESS OF AN EARLY INVASIVE VS. CONSERVATIVE STRATEGY FOR THE TREATMENT OF ACUTE CORONARY SYNDROMES: APPLICATION OF A NET-BENEFIT REGRESSION APPROACH TO DATA FROM THE TACTICS-TIMI 18 TRIAL**

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**OBJECTIVES:** Prior results from the TACTICS-TIMI 18 trial demonstrated that an early invasive approach to the management of patients with unstable angina (UA) or non-ST-segment elevation myocardial infarction (NSTEMI) was cost-effective, with an estimated cost per life-year gained of $8371; for high-risk patients with ST-segment changes at baseline, $3224 per life-year gained. We examined the joint influence of diabetes and ST-segment changes on the cost-effectiveness of the early invasive strategy. **METHODS:** Inpatient hospital costs for the 1722 US, non-VA patients for the 6-month trial period were obtained from the UB92 and Medicare cost/charge ratios. Other costs included: physician, outpatient, medication, and productivity costs. Life-expectancy estimates for patients with acute MI/coronary heart disease from the Framingham Heart Study were used for patients who survived the trial with/without experiencing a non-fatal MI. Cost-effectiveness was evaluated in terms of cost per life-year gained. Regression analyses of the net monetary benefit across a range of ceiling ratios were used to obtain cost-effectiveness acceptability curves for subgroups defined by diabetes and ST-change status. **RESULTS:** Net monetary benefit regression analyses revealed a three-way interaction between diabetes, ST-changes and treatment group which approached significance (p < 0.10) for models based on a ceiling ratio of $14,000–$49,000. Associated cost-effectiveness acceptability curves suggest a probability that the invasive strategy is cost-effective for non-diabetic patients with ST-segment changes of >95% for ceiling ratios $4000 per life-year gained. At a ceiling ratio of $50,000, the probability of cost-effectiveness for diabetic patients without ST-changes is 56%, for diabetic patients with ST-changes, 73%, and for non-diabetic patients without ST-changes, 74%. **CONCLUSIONS:** In addition to ST-segment changes at presentation, the cost-effectiveness of an invasive strategy for patients with UA or NSTEMI varies by DM status. This analysis demonstrates the usefulness and efficiency of net-benefit regression for the evaluation of cost-effectiveness for different patient subgroups.