model was adjusted. Diabetics and non-diabetics were analysed separately. Data on effectiveness of 12 month treatment were taken from RIO-Diabetes (overweight/obese patients with T2DM) and RIO-Europe (overweight with co-morbidities/obese patients, without T2DM), respectively. Cost data were derived from published sources for the year 2006 using €2.39 as daily costs of rimonabant. A time horizon of 40 years and a discount rate of 3% were applied. Input model data were varied plus/minus 20% performing sensitivity analyses. RESULTS: The model shows that adding rimonabant to diet and exercise, in patients with BMI $\geq 30$ kg/m$^2$, or BMI $>27$ kg/m$^2$ and additional risk factors leads to an increased life expectancy as well as an improved quality of life. Costs per QALY were €12,322 (diabetics) and €46,966 (non-diabetics). Costs per QALYG were €87,788 (diabetics) and €12,590 (non-diabetics). Considering the internationally utilized threshold of €50,000 per QALYG, the treatment with rimonabant can be assessed as cost-effective. The robustness of this result was substantiated through sensitivity analyses. CONCLUSION: Based on the results of the Rainbow model, treating patients with rimonabant in combination with diet and exercise is associated with a benefit in effectiveness at acceptable costs from a SHI-perspective, compared to a modification of lifestyle alone.

**PCV32**

**COST-EFFECTIVENESS OF IRBESARTAN IN THE TREATMENT OF PATIENTS WITH HYPERTENSION, TYPE-2 DIABETES AND RENAL DAMAGE IN MEXICO**

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OBJECTIVES: To perform a cost-effectiveness analysis of irbesartan for the management of nephropathy in patients with hypertension, type-2 diabetes and microalbuminuria in the Mexican scenario. METHODS: The treatment of patients was simulated with early irbesartan, 300 mg daily (initiating in the microalbuminuria stage) and late irbesartan (initiating in the stage of manifest nephropathy). These strategies were compared with a control, consisting of standard anti-hypertensive therapy. The progression of microalbuminuria to nephropathy, increase in the doubling of serum creatinine, end stage renal disease (ESRD) to death, was simulated over a temporary horizon of 20 years, using a Markov model previously published and adapted to the Mexican scenario. The transition probabilities were based in the study named Irbesartan in Reduction of Microalbuminuria-2, and the study called Irbesartan in Diabetic Nephropathy Trial, and local sources. The costs and clinical outcomes were discounted to an annual rate of 3%, and the perspective of the public health care institutions in Mexico. RESULTS: With early irbesartan there was a gain of 539.1 years of life per 1000 treated patients, and with late irbesartan there was a gain of 131.1, both compared to control. After 20 years of treatment, early irbesartan prevented 87 cases of ESRD per 1000 patients treated, and late irbesartan prevented 54, both compared to control. The cost per life-year gained with early irbesartan was €22,998.93 and the cost per year free from ESRD with late irbesartan was €11,503.94. The sensitivity analysis showed that therapy with irbesartan is still cost-effective compared to conventional antihypertensive treatment after modifying various plausible assumptions. CONCLUSION: The addition of irbesartan to conventional antihypertensive therapy demonstrated an improvement in life expectancy and reduction in the years with ESRD. It represented a cost-effective option compared to control, which means greater efficiency in the treatment of hypertension patients with type-2 diabetes and microalbuminuria in Mexico.

**PCV33**

**RESOURCE USE AND TREATMENT COSTS FOR ACUTE DECOMPENSATED HEART FAILURE: ECONOMIC ANALYSIS OF THE SURVIVE TRIAL**

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OBJECTIVES: Acute decompensated heart failure (AHF) is life-threatening and a frequent cause of hospitalization for older persons. The SURVIVE randomized controlled trial compared levosimendan (levo) versus dobutamine (dob) with 180-day mortality as primary endpoint. All-cause mortality at 31 days was levo 12% and dob 14% (hazard ratio 0.85, p = 0.29) with a similar differential at 180 days (HR 0.91, p = 0.40). Presented here is the SURVIVE economic analysis. METHODS: SURVIVE was conducted in Russia, Poland, France, Israel, Finland, UK, Latvia, Germany, and Austria. Enrolled patients (N = 1327) required IV inotropic support after insufficient response to IV diuretics or vasodilators. Case report forms (CRFs) documented study drug administration, inpatient days (ICU, routine care), procedures (e.g., PTCA, CABG, ICD), and safety data, during initial admission. CRFs also described subsequent admissions during follow-up. Hospital cost was calculated according to length of day and procedures. Source of cost data was national hospital payment schedules for France, Germany, and UK. Cost for levo was not included in base case analysis. Cost-effectiveness analysis used average market price for levo with post-trial survival projected per published AHF methodology. RESULTS: Length of stay (days) during initial admission was identical (levo 14.4, dob 14.5, p = 0.96). During follow-up similar patterns were observed for number of hospital admissions (levo 0.7, dob 0.9, p = 0.25) and total hospital days (levo 11.5, dob 12.4, p = 0.46). Mean cost of initial hospital admission was similar (levo €5060, dob €4945, p = 0.91) as was total hospital cost for the complete trial episode (levo €5471, dob €5273, p = 0.93). Incremental cost per life year gained for levo relative to dob was less than €27,000 with greater than 50% likelihood. CONCLUSION: In SURVIVE hospital resource use and costs were similar for levo and dob. Based on the survival difference, levo is cost-effective relative to dob using accepted benchmarks.

**PCV34**

**COST-EFFECTIVENESS OF ATORVASTATIN PLUS AMLODIPINE VERSUS ATORVASTATIN PLUS ATENOLOL IN HYPERTENSIVE PATIENTS WITHOUT PREVIOUS CORONARY HEART DISEASE, NORMAL TO MILDLY ELEVATED CHOLESTEROL LEVELS AND AT LEAST 3 CARDIOVASCULAR RISK FACTORS**

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OBJECTIVES: To assess the cost per quality-adjusted-life-year (QALY) of Atorvastatin 10 mg (ATV) + Amlodipine 5/10 mg (AML) compared with Atenolol 10 mg (ATE) + ATV, in hypertensive patients with no history of coronary heart disease (CHD) with normal to mildly elevated cholesterol and with at least 3