with chronic left ventricular dysfunction at increased risk for sudden cardiac death as compared to current risk stratification methods for selection of patients for implanted cardiac defibrillators (ICD) versus medical therapy. METHODS: A Markov model was developed to evaluate the impact of using AdreView for evaluating NYHA II or III and a hypothetical cohort of patients with LV ejection fraction (EF) ≤ 50% for treatment with an ICD. AdreView risk-stratification was used to guide the treatment decision between ICD and medical therapy. The source of data for predicted probabilities, expected mortality rates, and treatment costs in year 2009 dollars are from the published literature. Monte Carlo Markov Imaging for Heart Failure (ADMIRE-HF) study. The model was developed from a societal perspective using a one-month cycle time, 3% discount rate and a lifetime time horizon. Sensitivity analysis was completed on cost, efficacy and relative risk ratios. RESULTS: AdreView had an incremental cost-effectiveness ratio (ICER) of $100,930 versus standard stratification methods. The number needed to screen to prevent one death over 5 years was 20. The model was sensitive to changes in utility values ($194,737-$112,123 / QALY), efficacy of ICD in low risk patients ($95,805-$107,388 / QALY) and efficacy of ICD in high risk patients ($81,578-$146,086 / QALY). The model was not sensitive to the AdreView cost, even at 200% of baseline ($104,068 / QALY). CONCLUSIONS: AdreView is a relatively cost-effective screening strategy versus current methods that can prevent sudden cardiac deaths within as few as 20 patient screenings. Further research on the use of AdreView in real-world settings is warranted.

OBJECTIVES: Compare the cost-effectiveness of rosuvastatin versus standard management on the use of AdreView to help in risk stratification (PCV72). RESULTS: The cost-effectiveness of rosuvastatin in the pivotal study for NYHA II or III was $271 compared to simvastatin, or $30 per additional 1% reduction in LDL-C in high risk patients ($8,158-$9,851 / QALY). The model was not sensitive to the rosuvastatin cost, even at 200% of baseline ($437 / QALY). CONclusIons: Rosuvastatin confers therapeutic benefits similar to what was modeled in this study. Selectively lowering CRP levels is only cost-effective in males ≥ 60 years.

PCV77 ROBUST UNIVARIATE AND MULTIVARIATE SENSITIVITY ANALYSIS CONFIRMS THAT ENOXAPARIN IS COST-SAVING TO THE PAYERS COMPARED WITH UFH FOR VTE PREVENTION IN PATIENTS WITH ISCHEMIC STROKE: ANALYSIS OF THE PREVAIL DATA T. Letourneau, 1 J. Lin, 1 S. Stewart, 1 S. Subramaniam, 1 P. Machado, 1 M. Wintman, 2 M. Wijeyewera, 2 L. Iseri, 1 van der Velden G, 1 Paulden M 1University of Western Ontario, London, ON, Canada, 2ypass-events U.S. Bridgewater, NJ, USA, 3Analytica International, New York, New York, USA. OBJECTIVES: A decision-analytic model using cost data and clinical information from the PREVAIL study showed that enoxaparin was cost-saving from the payer perspective compared with unfractionated heparin (UFH) for the prevention of venous thromboembolism (VTE) in patients with acute ischemic stroke (overall costs of clinical events plus drug costs: $2018 vs. $2913, respectively; difference $895 per patient). To test the robustness of the cost difference of enoxaparin versus UFH for VTE prevention after an acute ischemic stroke, univariate and multivariate sensitivity analyses were performed. METHODS: In the univariate analysis, the payer cost (2007$) for each clinical event (deep-vein thrombosis [DVT], pulmonary embolism [PE]), intracranial hemorrhage [ICH], major extracranial hemorrhage [MEH]) and minor extracranial hemorrhage [MnEH]) was adjusted individually, increasing or decreasing by 20%, while other parameters (drug costs, event rates) remained unchanged. The multivariate analysis was a Monte Carlo simulation (Crystal Ball software), where all the parameters were simultaneously varied in a random fashion within a range of ±20% over 10,000 trials. RESULTS: The cost of DVT was $13,499. When increased by 20% to $16,199, the difference between UFH and enoxaparin groups was $1,104; when decreased by 20% to $10,799, the difference was $86. The baseline costs were $20,635 for PE, $26,037 for ICH, $22,765 for MnEH and $815 for MnEH. When these were increased by 20%, the difference between enoxaparin and UFH groups was $928, $907, $859 and $89 respectively. When decreased by 20%, the difference was $862, $888, $932 and $984. Using the Monte Carlo simulation multivariate analysis, the difference varied between $645 and $1,777, with mean $308 ($896 median) and standard error of $897. Enoxaparin was less costly than UFH across all analyses, with DVT being the main cost driver. CONCLUSIONS: Univariate and multivariate sensitivity analysis confirmed that enoxaparin is more cost-saving than UFH for VTE prevention after an acute ischemic stroke.
OBJECTIVES: The purpose was to conduct a cost-effectiveness analysis (CEA) of enoxaparin versus fondaparinux in the treatment of deep-vein thrombosis (DVT) in Poland. METHODS: Data concerning efficacy and safety of compared therapies were taken from the clinical-effectiveness analysis which was based on the systematic literature review. Due to lack of statistically significant differences in comparison of enoxaparin versus fondaparinux, economic profitability estimation was performed as a cost-minimization analysis. Decision model was created by using MS Excel. Total costs of analysed therapies were estimated from the perspective of both payers in Poland (National Health Fund and patient). The minimisation analysis involved comparison of treatment with enoxaparin (1 mg/kg body mass, twice daily) versus fondaparinux (5, 7.5 or 10 mg—depending on the patient's body mass, once daily). The time horizon of the analysis manage PAH in patient with WHO Functional Class III, patients, each of whom was divided into two groups: the therapy group (treated with fondaparinux) and the control group (treated with enoxaparin). The analysis has been performed using a five-state Markov model. The time horizon of the analysis was 1 year (consistent with clinical trials). It was assumed that the probability that fondaparinux be cost-effective is close to one, while for enoxaparin is negligible. CONCLUSIONS: Regarding AMI reduction and avoided myocardial revascularization, fondaparinux represents a cost-effective antithrombotic therapy in Mexican patients who suffered UAFE. DVT due its higher efficacy and reasonable incremental costs.

ECONOMIC ANALYSIS OF ENOXAPARIN IN COMPARISON WITH FONDAPARINIX IN THE TREATMENT OF DEEP-VEIN THROMBOSIS (DVT)

Wojcik J, Noga G, Galaska M, Paniuk J, Lin J, Obreut G

Archiwum Medycyny Wewnętrznej, crankow, Poland.

OBJECTIVES: The purpose of this study was to estimate the cost-effectiveness of different antithrombotic agents in the management of UAFE, from the institutional perspective. METHODS: A seven-state Markov model was performed to estimate health and economic consequences during a time horizon of five weeks (one-week cycles). Effectiveness measures were reduction in incidence of acute myocardial infarct (AMI) and recurrence of angina, as well as avoided events of myocardial revascularization and deaths associated with acute coronary syndrome. Transition probabilities were obtained from a meta-analysis employing international published literature. Doses of comparators used in the analysis were: dalteparin (240 IU/kg/day); enoxaparin (2 mg/kg/day); fondaparinux (mg/ day); nadroparin (172 IU/kg/day) and unfractionated heparin (UFH 15,000 IU/day). Resource use was obtained from the Social Security Mexican Institute hospital records (n = 5009). Costs were extracted from government and institutional sources and include hospitalization, drugs, medical procedures, imagiography, laboratory tests and adverse events management. Probabilistic sensitivity analyses were performed employing bootstrapping analysis. Acceptability curves were constructed. RESULTS: Dalteparin, enoxaparin, fondaparinux, nadaparin and UHF (reference alternative) associated costs per patient were: US$5501 (+19%), US$5231 (+20%), US$2262 (+6%), US$2556 (+21%) and US$2179, respectively. Dalteparin is the only alternative that is more costly than dalteparin. Incremental cost-effectiveness ratios (ICER [95%CI]) for dalteparin compared to UFEH were US$1,916 (US$10,703-US$11,128) and US$3,509 (US$4,400-US$5,577), per additional AMI reduced and additional myocardial revascularization avoided, respectively. At a willingness to pay of US$15,800 per additional AMI avoided, acceptability curves showed that the probability that dalteparin be cost-effective is close to one, while for enoxaparin is negligible. CONCLUSIONS: Regarding AMI reduction and avoided myocardial revascularization, dalteparin represents a cost-effective antithrombotic therapy in Mexican patients who suffered UAFE due its higher efficacy and reasonable incremental costs.

ECONOMIC ANALYSIS OF ENOXAPARIN IN COMPARISON WITH FONDAPARINIX IN THE TREATMENT OF DEEP-VEIN THROMBOSIS (DVT)

Wojcik J, Noga G, Galaska M, Paniuk J, Lin J, Obreut G

Archiwum Medycyny Wewnętrznej, crankow, Poland.

OBJECTIVES: The purpose of this study was to estimate the cost-effectiveness of different antithrombotic agents in the management of UAFE, from the institutional perspective. METHODS: A seven-state Markov model was performed to estimate health and economic consequences during a time horizon of five weeks (one-week cycles). Effectiveness measures were reduction in incidence of acute myocardial infarct (AMI) and recurrence of angina, as well as avoided events of myocardial revascularization and deaths associated with acute coronary syndrome. Transition probabilities were obtained from a meta-analysis employing international published literature. Doses of comparators used in the analysis were: dalteparin (240 IU/kg/day); enoxaparin (2 mg/kg/day); fondaparinux (mg/ day); nadroparin (172 IU/kg/day) and unfractionated heparin (UFH 15,000 IU/day). Resource use was obtained from the Social Security Mexican Institute hospital records (n = 5009). Costs were extracted from government and institutional sources and include hospitalization, drugs, medical procedures, imagiography, laboratory tests and adverse events management. Probabilistic sensitivity analyses were performed employing bootstrapping analysis. Acceptability curves were constructed. RESULTS: Dalteparin, enoxaparin, fondaparinux, nadaparin and UHF (reference alternative) associated costs per patient were: US$5501 (+19%), US$5231 (+20%), US$2262 (+6%), US$2556 (+21%) and US$2179, respectively. Dalteparin is the only alternative that is more costly than dalteparin. Incremental cost-effectiveness ratios (ICER [95%CI]) for dalteparin compared to UFEH were US$1,916 (US$10,703-US$11,128) and US$3,509 (US$4,400-US$5,577), per additional AMI reduced and additional myocardial revascularization avoided, respectively. At a willingness to pay of US$15,800 per additional AMI avoided, acceptability curves showed that the probability that dalteparin be cost-effective is close to one, while for enoxaparin is negligible. CONCLUSIONS: Regarding AMI reduction and avoided myocardial revascularization, dalteparin represents a cost-effective antithrombotic therapy in Mexican patients who suffered UAFE due its higher efficacy and reasonable incremental costs.

ECONOMIC ANALYSIS OF ENOXAPARIN IN COMPARISON WITH FONDAPARINIX IN THE TREATMENT OF DEEP-VEIN THROMBOSIS (DVT)

Wojcik J, Noga G, Galaska M, Paniuk J, Lin J, Obreut G

Archiwum Medycyny Wewnętrznej, crankow, Poland.

OBJECTIVES: The purpose of this study was to estimate the cost-effectiveness of different antithrombotic agents in the management of UAFE, from the institutional perspective. METHODS: A seven-state Markov model was performed to estimate health and economic consequences during a time horizon of five weeks (one-week cycles). Effectiveness measures were reduction in incidence of acute myocardial infarct (AMI) and recurrence of angina, as well as avoided events of myocardial revascularization and deaths associated with acute coronary syndrome. Transition probabilities were obtained from a meta-analysis employing international published literature. Doses of comparators used in the analysis were: dalteparin (240 IU/kg/day); enoxaparin (2 mg/kg/day); fondaparinux (mg/ day); nadroparin (172 IU/kg/day) and unfractionated heparin (UFH 15,000 IU/day). Resource use was obtained from the Social Security Mexican Institute hospital records (n = 5009). Costs were extracted from government and institutional sources and include hospitalization, drugs, medical procedures, imagiography, laboratory tests and adverse events management. Probabilistic sensitivity analyses were performed employing bootstrapping analysis. Acceptability curves were constructed. RESULTS: Dalteparin, enoxaparin, fondaparinux, nadaparin and UHF (reference alternative) associated costs per patient were: US$5501 (+19%), US$5231 (+20%), US$2262 (+6%), US$2556 (+21%) and US$2179, respectively. Dalteparin is the only alternative that is more costly than dalteparin. Incremental cost-effectiveness ratios (ICER [95%CI]) for dalteparin compared to UFEH were US$1,916 (US$10,703-US$11,128) and US$3,509 (US$4,400-US$5,577), per additional AMI reduced and additional myocardial revascularization avoided, respectively. At a willingness to pay of US$15,800 per additional AMI avoided, acceptability curves showed that the probability that dalteparin be cost-effective is close to one, while for enoxaparin is negligible. CONCLUSIONS: Regarding AMI reduction and avoided myocardial revascularization, dalteparin represents a cost-effective antithrombotic therapy in Mexican patients who suffered UAFE due its higher efficacy and reasonable incremental costs.