short- and long-term effectiveness of EECP. Although the ENBS depends on the cost-effectiveness threshold, the ENBS is positive for most sample sizes indicating that further experimental research will be efficient. A clinical trial design is proposed with equal allocation of patients between arms. Given a threshold of $20,000 per QALY gained, the ENBS is positive for most sample sizes which will be confirmed with a 4-year follow-up and an optimal sample size of 900. CONCLUSIONS: Expert elicitation and value of sample information can be combined into a single coherent framework to establish the value of further research, the optimal design of such research, and the most appropriate basis for informing cost-effectiveness.

ENOXAPARIN VERSUS UNFRACTIONATED HEPARIN FOR THE NON-INVASIVE MANAGEMENT OF PATIENTS WITH NON-ST-SEGMENT ELEVATION MYOCARDIAL INFARCTION (NSTEMI) – A CORONARY SYNDROMES (NSTE-ACS): THE PHARMACOECONOMIC EVALUATION IN RUSSIA

Syrov A1,ZYryanov S2,Belousov VB1
Moscow hospital of GIU1, Moscow, Russia, “Russian State Medical University, Moscow, Russia

OBJECTIVES: To compare one-day cost efficacy and safety of enoxaparin 1 mg/kg subcutaneous injection twice daily with unfractionated heparin intravenous infusion for the conservative management in patients with NSTE-ACS. METHODS: Eighty patients were enrolled in the study and received enoxaparin 10 mg/kg subcutaneous injection twice daily (n = 40) or unfractionated heparin intravenous infusion (n = 40) for the conservative management in patients with NSTE-ACS. Treatment efficacy was evaluated on the basis of the combination of clinical, ECG and laboratory indexes. The therapy considered to be successful in case of death, nonfatal myocardial infarction (MI), early angiography with subsequent revascularization and major bleeding. RESULTS: Total expenses per 1 patient (only direct costs) and cost/effect ratio were calculated for each anticoagulant group. The following cases were recorded in unfractionated heparin group: one death, two major bleedings, and five MIs. Treatment success probability was 80%, while total expenses per 1 patient stood at 16,489 rubles and cost/effect ratio accounted for 38,111 rubles per each effective treatment (current exchange rate $15 = 29 rubles). Enoxaparin showed 3 MIs and 1 performed acute angioplasty. Treatment efficacy was 90% while total expenses per 1 patient was 46,991 rubles and cost/effect ratio was 52,214 rubles per 1 effective treatment. After compare the costs of treatment and its efficacy in both groups enoxaparin proved to be the most cost-effective anticoagulant due to the smallest total expenses and cost/effect ratio. CONCLUSIONS: Medical treatment with enoxaparin 1 mg/kg twice daily for patients with NSTE-ACS proved to be more beneficial in terms of cost and efficacy than permanent intravenous infusion of unfractionated heparin.

A COST-EFFECTIVENESS ASSESSMENT OF DALTEPARIN AS A PROPHYLACTIC AND THERAPEUTIC AGENT FOR THE MANAGEMENT OF THROMBOEMBOLIC VENOUS DISEASE (VTE) IN MEXICAN ADULT PATIENTS AFTER TOTAL HIP REPLACEMENT

Arreola-Ornelas H1, Rosado-Buzzo AA2, Garcia-Mollinedo MDL2, Dorantes-Aguilar J1, Moudi-Quevedo J1, Davila-Loaiza G1
Fondo Mexico para la Salud, Mexico City, Mexico, “Universidad National Autonoma de Mexico, Mexico City, Mexico, “Pfizer Mexico, Mexico City, Mexico

OBJECTIVES: To assess the cost-effectiveness of different anticoagulant treatments to prevent VTE associated with hip surgery from the health care payer's perspective. METHODS: A six-state stochastic Markov model was performed to estimate costs and effectiveness during a time horizon of one-year (1-week cycles). Effectiveness measures were reduction in incidence of VTE and death; reduced hospitalizations and avoidance of death. Transition probabilities were obtained from a meta-analysis involving national and international published literature. Comparators used in the assessment were warfarin (5 mg/day); dalteparin (2500, 5000, 7500 IU/day); acenocoumarol (4 mg/day); enoxaparin (20,40,60 mg/day); nadroparin (50,0 mg/day); UFH plus warfarin (10,000,30,000,42,000 IU/day+5 mg/day); unfractionated heparin (UFH) plus warfarin (10,000,30,000,42,000 IU/day+5 mg/day); and no prophylaxis intervention. RESULTS: Incidence of PE and VTE were significantly lower in patients receiving dalteparin treatment (p < 0.05). Regarding the reduction of VTE events, dalteparin 2500, 5000 and 7500 IU/day showed an ICER[95%] of US$1,256.09[US$1,252.47–US$1,259.71]; US$1,918.49[US$1,915.24– US$1,921.74]; and US$3,353.56[US$3,349.69–US$3,357.43] respectively. In addition, UFH yielded an ICER of US$92,760.79[US$92,732.64–US$92,788.93] against warfarin, respectively. Dalteparin showed the lowest number of deaths and hospital readmissions when compared to other anticoagulant treatments (p < 0.05) reducing significant costs in the short term within an institutional Mexican setting. Second-order Monte Carlo analyses showed evidence that dalteparin would be more cost-effective than enoxaparin in a range of 60%–70% (p < 0.05). CONCLUSIONS: In Mexico, dalteparin demonstrated to be a cost-effective anticoagulant therapy to reduce the incidence of PE and VTE and avoid death and hospital re-admissions in the management of adultpatients after total hip replacement. These results should be taken into account by Mexican health professionals to generate cost-containment strategies.