SIONS: Patients starting a treatment with COXIBs + GPAs are likely to have a previous history of GIDs significantly more severe and costly than patients who continue NSAIDs + GPAs. This constitutes a confounding factor when assessing therapy effectiveness and safety, in particular when evaluating co-prescription rates with GPAs in patients treated with anti-inflammatories.

**ANALYSIS OF CONSUMPTION OF NON-STEROID ANTIINFLAMMATORY DRUGS (GROUP M01) AT NATIONAL LEVEL IN DDD/1000/DAY: 1999–2001**

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OBJECTIVES: To focus on the Bulgarian market of M01 group for the period 1999–2001; the most consumptive active principles (APs) within M01; to determine the trend in M01 consumption and within. METHODS: M01 consumption at national level has been calculated by ATC/DDD methodology and expressed in DDD/1000/day. Data have been collected from: a) the import of wholesalers, b) the local industry sale reports for the domestic market. Comparison has been made with M01 consumption in Norway and Sweden (expressed in DDD/1000/day). RESULTS: M01 consumption at national level has been calculated as follows: 1999—14,216; 2000—13,764; and 2001—15,565. The most consumptive APs within M01 were: Diclofenac (D) 1999—8,448; 2000—8,728; and 2001—9,753; Piroxicam (P) 1999—3,380; 2000—2,892; and 2001—2,761; Indometacin (Ind) 1999—1,457; 2000—1,061; and 2001—1,104; Ketoprofen (K) 1999—0,192; 2000—0,439; and 2001—0,699; Tenoxycam (T) 1999—0,598; 2000—0,172; and 2001—0,699. Ibuprofen (Ib) consumption was: 1999—0,169; 2000—0,030; and 2001—0. The coxib Rofecoxib (R) consumption was registered initially in 2001—0,054. CONCLUSIONS: M01 consumption 1999–2001 did not show significant variations. The national demand for M01 is approximately 14 DDD/1000/day. M01 consumption in Norway and Sweden was higher. D as the most consumptive AP at a national level was about 67% of M01 consumption due to 4 locally produced products. Dynamics within the group was: D and K increased slightly; Ind showed relatively steady-state position; P slightly decreased; the trend in T consumption could not be defined distinctly; Ib decreased in consumption; Coxibs were with limited place within M01. In comparison with Bulgaria, M01 consumption model in Norway and Sweden showed some differences.
OBJECTIVES: To determine the incremental cost per life year saved (CLYS) for France, Germany and UK, of clopidogrel versus aspirin in secondary prevention of ischemic events (myocardial infarction, ischemic stroke, vascular death) in three high-risk populations of atherothrombotic patients (history of cardiac surgery, prior ischemic stroke or myocardial infarction, hypercholesterolemia or diabetes) from the CAPRIE randomised clinical trial.

METHODS: A Markov model designed with several clinical states calculated CLYS as the cost needed to achieve an extra life year with clopidogrel compared with aspirin. The model combined rates of clinical outcomes (fatal or non-fatal) reported in CAPRIE, with survival data derived from the Framingham database and costs of outcomes assessed from external sources. Life expectancy was corrected according to the level of risk of patients. The economic analysis was performed with local unit costs from the health care system perspective with a time horizon of two years. Both costs and benefits were discounted (according to local guidelines). CLYS obtained for high risk populations were compared with CLYS calculated for the overall CAPRIE population. RESULTS: For France, when compared to CLYS obtained for overall population (€15,907), CLYS for patients with history of prior cardiac surgery was decreased by 90% (€1,570), CLYS for patients with prior ischemic stroke or myocardial infarction by 55% (€7,202) and by 24% for CLYS for population with hypercholesterolemia or diabetes (€12,018). Similar decreases in ratios for these high-risk populations were found in Germany and UK. CONCLUSION: The economic analysis shows more favourable cost-effectiveness results for high-risk populations compared to overall CAPRIE population. All CLYS figures are within acceptable ranges and compare favourably with other therapeutic strategies for secondary prevention of ischemic events.

PHYSICIAN CHARACTERISTICS OF THE NAVIGATOR TRIAL PREDICT AVERAGE LENGTH OF STAY (ALOS) IN ACUTE CORONARY SYNDROME (ACS)

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OBJECTIVES: The NAVIGATOR trial will evaluate the impact of nateglinide and valsartan on the progression to diabetes in subjects with impaired glucose tolerance at high risk for a cardiovascular event. Investigators in this trial include endocrinologists, cardiologists and general internists. Although economic evaluations of clinical trials typically adjust for country, little is known about how physician-specific characteristics may affect ALOS. Our objective was to determine which physician characteristics would be independent predictors of ALOS for myocardial infarction (MI).

METHODS: We analyzed responses from a survey of NAVIGATOR investigators to determine factors associated with self-reported ALOS in the treatment of MI. Candidate predictors in the multiple regression model were physician age, sex, years since graduation, medical specialty, practice environment, and geographic region. This relationship was examined using linear regression. RESULTS: 383 respondents with complete data were included in the model. Physician age, sex, years since graduation, specialty of internal medicine, practice setting (solo or group), and geographic region met the criterion for inclusion in the multivariable model. Male physicians reported an ALOS 3 days shorter than female doctors (p < .0001). Physicians in group practice were associated with a 1-day longer ALOS as compared to hospital-affiliated physicians (p = < .0001). All geographic regions except for Africa and Canada were significantly associated with longer ALOS than the US (Asia Pacific 6 days, Eastern Europe 9, Europe 3.5, Latin America 2) (p = < .0001 for all). CONCLUSIONS: For NAVIGATOR investigators, physician sex, practice setting and geographic region are predictors of ALOS. We will adjust for physician characteristics in the economic analysis of the NAVIGATOR trial. We conclude that measuring physician characteristics should be incorporated into multinational clinical trials.