episodes involving inpatient care and complications could lower substantially the burden of diabetes.

PCV82
REAL WORLD EVIDENCE AND COSTS OF CHRONIC HEART FAILURE: FINDINGS FROM THE ARNO DATABASE
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OBJECTIVES: Patients with chronic heart failure (HF) in controlled trials do not fully represent real population followed in clinical practice. We wanted to give real world picture of epidemiology and hospitalization characteristics of patients with HF, by using administrative database of nearly 500,000 subjects. Evaluation of healthcare related costs over 1 year follow-up was performed.

METHODS: Data come from ARNO database that includes in-habitants of 7 Local Health Authorities of the National Health Service (NHS). Patients were selected when admission for HF occurred over period of 5 years (January 1, 2008 to December 31, 2012). To confirm diagnosis, all patients discharged alive should be prescribed typical treatment for HF. Clinical characteristics co-morbidities, treatment, need for re-hospitalization were collected. Total costs for NHS were calculated as hospitalizations, treatments and of-out hospital stays. Hospitalizations studies were divided in hospitalizations for general medical conditions (HCRU) and treatment costs of non-valvar HF (NVAF) patients with and without stroke.

METHODS: Retrospective cohort study of patients newly diagnosed with NVAF from January 2003 to December 2013. Patients were identified using medical diagnosis coding system (ICD-9-CM). The treatment period (collected in the ARNO database) includes the first year of diagnosis or the start of the index anticoagulant prescription. The number of stays with a DVT/PE episode was retrieved in the database. The number of stays with a DVT/PE episode was respectively equal to 22 and 43 within the two subgroups, resulting in an incidence of 0.001 episodes per patient with hip replacement and 0.005 in patients with knee replacement. LOS of patients with a DVT/PE episode was more than twice as high after both hip (35.8 vs. 13.59 days; p < 0.001) and knee (13.12 vs. 9.9 days; p < 0.001) replacement.

Hospitalization costs were more than doubled in case of DVT/PE complication (€ 25,557 vs. € 12,721 in hip replacement; € 24,953 vs. € 11,298 in knee replacement; p < 0.001 in both cases).

CONCLUSIONS: The incidences of symptomatic DVT and PE reported in the literature could be confirmed based on this retrospective search. The occurrence of DVT/PE increased dramatically both LOS and hospitalization costs in patients undergoing hip or knee surgery.

PCV86
DIRECT TREATMENT COSTS OF STROKE IN TURKEY
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OBJECTIVES: Stroke is the second leading cause of death globally and the survivors are faced with long-term disability. Stroke survivors are also under the risk of recurrent events and facing a potential healthcare cost for the rest of their life. This study was aimed at estimating the long-term direct costs of stroke in Turkey.

METHODS: A multi-dimensional approach was used to estimate the direct costs of stroke in Turkey. First a large dataset covering 5 years data for 2000 and 2001 were retrieved from the hospitals. The data set covered information on the severity of the disease, socioeconomic status of the patients and also the medical procedures applied during the hospital stay. Second, the actual invoices of the same patients hospitalized in 2014 were analyzed. Third, a form was designed to explore the treatment strategies, medical procedures and resource requirements of stroke outpatients and inpatients. The form was applied to an expert panel and the resources determined by the panel were priced by the Social Security Institution’s official price list.

RESULTS: According to the expert panel part of the study, annual outpatient and monitoring costs were € 2,557 and 58,572, respectively. € 1,807,58,57, intensive care and inpatient costs were 56,53,52, the total annual cost of stroke per patient was calculated as € 7,444,11 TL in Turkey. CONCLUSIONS: The study showed that stroke treatment could consume a significant part of the healthcare budget. Outpatient and monitoring costs constituted 52% of total costs whereas inpatient costs constituted 57% of total costs.