trial. Country-specific unit costs data were obtained from national sources. Costs are reported in 2007 euro. RESULTS: Indoxilan is cost-effective compared to iohexol with both lower costs and better effects related to fewer ADRs. For Germany, Italy, Spain, Sweden, and UK, respectively, the mean per patient cost differences due to the reduction in ADRs were €444, €431, €574, €859, and €753. CONCLUSIONS: Indoxilan results in fewer ADRs and resulted in lower ADR costs per patient for this high-risk patient population across the five European countries.

PCV55
PHARMACEUTIC-ECONOMIC EVALUATION OF TREATMENT WITH PROCORALAN® PREPARATION COMPARED TO INVASIVE TREATMENT
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OBJECTIVES: To determine economic impact of Procoralan® therapy in stable angina patients as compared to invasive PCI/CABG therapy. METHODS: A cost-minimisation, probabilistic model performed from a third party payer perspective in Poland. Costs calculations were based on the National Health Fund rates. Invasive therapy cost was assumed to be a weighted average of PCI/CABG, according to Poland-specific proportions. Clinical assumptions and risk profiles were derived from the Euro Heart Survey. The economic impact was calculated for the patients not qualified for invasive therapy or maintenance therapy with beta-blocker due to contraindications or intolerance. Both one-way (drug cost) and multi-way (revascularisation risk, reimbursement level) sensitivity analyses were performed. RESULTS: The incremental costs per patient per year were as follows: €747.82–743.34 for Procoralan® 5 mg/7.5 mg therapy respectively; €3879.88 for CABG, €2265.88 for PCI. The reduction in payer’s expenditure in the range of €1918.32–1922.81 per patient per year was demonstrated as a result of the application of Procoralan® 5 mg/7.5 mg therapy instead of the invasive therapy. The obtained result applies to the case of the whole Procoralan® price borne by the payer (100% reimbursement). In the case of 70% and 50% reimbursement rates savings amounted to €2112.09–2115.23 and €2248.05–2250.20 depending on dose of the drug. The sensitivity analyses results showed that change of the Procoralan® treatment cost (+/-50%), wide range of changes in the risk of a secondary revascularisation and the reimbursement level did not influence the ultimate interpretation of the results. CONCLUSIONS: Third party payer’s benefits related to Procoralan® may apply to all patients suffering from angina symptoms having contraindications or intolerance to beta-blocker. The greatest savings concern patients not qualified for invasive therapy as no alternative treatment is effective in this group, but in all scenarios the Procoralan® therapy was proven to be cost-saving for public payer.

PCV56
AN ECONOMIC ANALYSIS OF INDUCTION OF LABOR AND EXPECTANT MANAGEMENT IN WOMEN WITH PREGNANCY-INDUCED HYPERTENSION OR PREECLAMPSIA AT TERM (HYPITAT TRIAL)
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OBJECTIVES: To compare the costs of induction of labor with the costs of an expectant management strategy in women with pregnancy-induced hypertension (PIH) or preeclampsia (PE) at term. METHODS: The Hypertension and Preeclampsia Intervention Trial At Term (HYPITAT) was a multicentre randomized controlled clinical trial conducted in The Netherlands between October 2005 and April 2008. Women diagnosed with PIH or PE at ≥36 weeks of gestation were randomly allocated to either induction of labor or expectant management. The study showed that induction of labor reduced both maternal complications as well as the caesarean section rate as compared to expectant management. The economic analysis was performed from a societal perspective. Resource utilization was documented by specific items in the Case Report Forms (CRF) and additional questionnaires. For most medical unit costs, we used estimates provided by the financial and economic departments of two participating hospitals (one academic and one general hospital). For non-medical costs and primary care costs Dutch standardized prices were used. Sensitivity analyses were performed to explore the impact of different assumptions and cost estimates on the results of the costs analysis. RESULTS: Data of 756 women were analyzed. Mean costs per patient were €5400 for induction and €6025 for expectant management (difference €625). This 10% difference predominantly originated in the ante partum period: per patient €977 for induction versus €1929 for expectant management. Comparable costs were found for delivery (€761 versus €790 per patient). No substantial differences were found in the post partum period. CONCLUSIONS: In women with PIH or PE at term, costs associated with induction of labor are considerably lower as compared to expectant management. This cost reduction is mainly due to differences in resource utilization in the ante partum period.

PCV57
ESTIMATING THE NUMBER AND COST OF CARDIOVASCULAR EVENTS AVOIDED BY TREATING TO ALTERNATIVE LDL-C TARGETS: IS LOWER BETTER?
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OBJECTIVES: To estimate the number and cost of cardiovascular (CV) events avoided over five years by treating with statins to alternative low-density lipoprotein cholesterol (LDL-C) targets of <3.0 mmol/L and <2.0 mmol/L, based on 1000 patients with established cardiovascular disease (CVD) or diabetes from an NHS perspective. METHODS: Proportional effects per mmol/L LDL-C reduction for non-fatal myocardial infarction (MI), coronary revascularisation and stroke were taken from a meta-analysis of 14 randomised controlled trials of statin therapy. Absolute risk reductions (ARR) between control and treatment arms were calculated. Baseline LDL-C value of 3.6 mmol/L (SD 1.27) was taken from the Health Survey for England 2003 and 5000 LDL-C values <3.0 mmol/L and ≥2.0 mmol/L were randomly generated from this distribution giving mean baseline LDL-C values of 4.24 mmol/L and 3.86 mmol/L respectively. Absolute LDL-C reductions needed to meet the alternative targets were calculated and ARR in CV event incidence applied. The % reduction in CV events for 1000 patients was used to estimate number of CV events avoided; costs of events avoided were calculated using the National Tariff 2007-08. RESULTS: ARR between control and treatment arms was 1.8%, 1.8% and 0.6% for MI, coronary revascularisation and stroke respectively. Absolute reduction required to meet the LDL-C target of <3.0 mmol/L was 1.24 mmol/L, resulting in 51 CV events avoided (22 MIs; 22 CABG/PTCA; 7 strokes), with a total cost saving of £220,714 (MI = £70,158; CABG/PTCA = £130,368; stroke = £20,188). The 1.86 mmol/L required to meet the LDL-C target <2.0 mmol/L resulted in the 77 CV events avoided.
COSTS OF CORONARY ARTERY DISEASE (CAD) IN POLAND

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OBJECTIVES: A representative evaluation of CAD costs in Poland including General Practitioners (GPs) and Specialists’ (S) settings. METHODS: A representative sample of 2593 Polish patients with confirmed CAD (1977 patients under GP’s care, 616 patients under S care). A time horizon of the analysis was 12 month and a retrospective approach was applied. The study estimated both direct medical and indirect costs resulted from sick leaves, pensions and sickness benefits. Unit costs were obtained from available published data derived from the National Health Fund and the Polish Social Insurance Institution. A prevalence based method using National Statistical Office data was used to estimate economic burden of CAD. RESULTS: The distribution of total costs was similar in the GPs’ and specialists’ settings. Hospitalisation and invasive treatment constituted main direct medical costs’ drivers in both conditions. The average direct medical cost per CAD patient reached annually €1079.09. The average societal cost €1437.19 when the merely indirect costs related to the absence from work (€358.10) was included. Average cost covering also indirect cost related to the patients’ disability increased to the €2254.17. The total average costs were significantly (14.4%) higher in S’s than in GPs’ settings. In accordance with the lowest boundary estimate of CAD prevalence rate (2.9%), the total, societal burden of CAD in Poland in 2005 amounted to €2036.7 million. More than half of this cost (52.1%) was due to the indirect cost, 69.5% of which resulted from patients’ disability. CONCLUSIONS: CAD imposes a high economic burden for the third party payer as well as for Polish society. Clearly, there is a need to develop and apply innovative, cost-effective treatment strategies that will reduce the need for hospitalisation and invasive treatment and may successfully be implemented in the GPs’ practice.

PCV58

TWO-YEAR HOSPITALIZATION RATES AND ASSOCIATED COSTS IN PATIENTS FROM GERMANY WITH PERIPHERAL ARTERIAL DISEASE: RESULTS FROM THE REDUCTION OF ATEROTHROMBOSIS FOR CONTINUED HEALTH (REACH) REGISTRY

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OBJECTIVES: Atherothrombosis is the leading cause of death worldwide with huge economic burden. Peripheral arterial disease (PAD), a marker of disseminated vascular disease, puts patients at a high risk of atherothrombotic events. The REACH Registry is an international prospective registry of 67,888 patients from 44 countries at risk of atherothrombosis due to coronary artery disease (CAD), cerebrovascular disease (CVD) and/or PAD, or the presence of ≥3 atherothrombotic risk factors. PAD at enrollment was identified on the basis of current intermittent claudication with either ankle brachial index (ABI) < 0.9, or history of lower limb revascularization (angioplasty/stenting, peripheral bypass graft) or amputation. METHODS: We examined 2-year rates of vascular-related hospitalizations and associated costs in 1303 REACH patients from Germany with established PAD at baseline. Poisson regression was used to identify independent predictors of vascular hospitalizations. The costs per DRG for vascular hospitalizations were derived from the German 2004 Case Fees Catalogue. RESULTS: At baseline, mean age was 68 years, 29% female, 46% diabetes, 76% had ABI < 0.9, 56% had prior lower limb revascularization, 13% prior amputation, 63% had other involved vascular territories (479 CAD + PAD; 136 CVD + PAD; 205 CAD + CVD + PAD). There were 360 (28%) patients who had ≥1 vascular hospitalizations at 2 years. Significant (p < 0.05) independent baseline predictors of an increased hospitalization rate included diabetes, female, ABI < 0.9, prior peripheral revascularization, prior amputation, CAD, hypertension, decreasing age and prior smoking. Mean vascular hospitalization costs per patient were: €23595 overall, €3052 female/€2423 male; €3351/€1973 with/without diabetes; €2773/€2394 with/without prior lower limb revascularization; €2787/€2578 with/without prior amputation.

PCV60

INPATIENT RESOURCE USE ASSOCIATED WITH THE TREATMENT OF SECONDARY ATRIAL FIBRILLATION

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OBJECTIVES: We estimated incremental inpatient costs and length of stay (LOS) attributable to secondary atrial fibrillation (AF) in patients with and without cardiac predisposing factors to document the economic burden of this disease. METHODS: We extracted 2004–2005 discharges from Premier Perspective(tm), the largest hospital database in the US, with a secondary AF diagnosis and matched controls that had neither a primary nor a secondary AF diagnosis. We matched on patient age, discharge date, facility type and primary diagnosis category. We used regression models to estimate the incremental inpatient costs and LOS due to secondary AF. We adjusted for comorbidities, demographic and hospital-specific factors. We repeated this analysis for patients without cardiac predisposing factors (i.e. mitral valve disease, heart failure, non-AF cardiac operation, chest pain and congestive artery disease). RESULTS: The estimated 5.4 million secondary AF discharges in the US during 2004 and 2005 had an adjusted average inpatient cost of $12,292. This cost was $3532 more than the adjusted average inpatient cost for controls without AF (P < 0.0001). Patients with secondary AF had an adjusted average LOS of 7.8 days or 1.9 additional days compared to controls without AF (P < 0.0001). The estimated 1.4 million secondary AF discharges without cardiac predisposing factors had an adjusted average inpatient cost of $8956, an increase of $1908 compared to controls without AF or cardiac predisposing factors (P < 0.0001). Secondary AF patients without cardiac predisposing factors had an adjusted average LOS of 6.2 days or one additional day compared to controls (P < 0.0001). CONCLUSIONS: Inpatient costs and LOS were significantly higher for patients with a secondary AF discharge diagnosis when compared to controls that did not have an AF diagnosis. These differences, although still significant, were less pronounced among patients without cardiac predisposing factors. Further research is warranted to investigate how secondary AF is most cost-effectively treated.