ment as well as anginal pains. Rate of arrhythmia at discharge was minimal in streptokinase group. Alteplase required much more costs than streptokinase or treatment without thrombolytical therapy. ICER was 252,454.31 rubles ($7889.20) per absence of heart failure at discharge for alteplase vs streptokinase, and 166,720.5 rubles ($5210.02) for alteplase vs treatment without thrombolytical therapy. Still streptokinase was more cost-effective vs treatment without thrombolytical therapy: ICER was 4038.76 rubles ($126.21) per absence of heart failure at discharge. **CONCLUSION:** Alteplase is less cost-effective thrombolytical strategy for MI than streptokinase in spite of higher effectiveness.

PCV10

THE COST-EFFECTIVENESS OF CLOPIDOGREL IN PATIENTS UNDERGOING PERCUTANEOUS CORONARY INTERVENTION IN SWEDEN: AN ANALYSIS OF PCI-CURE

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OBJECTIVES: We assessed the long-term cost-effectiveness of the use of clopidogrel on top of standard therapy (including aspirin) in comparison with ASA only in patients undergoing percutaneous coronary interventions in Sweden. **METHODS:** A Markov model was developed. Transition probabilities for relevant events were estimated based on RIKS-HIA, a register on patients treated in the coronary care units at 74 (out of 78) hospitals throughout Sweden. Patients were assumed to be treated for one year with an effect based on the PCI-CURE trial. Costs for the intervention and the defined events were collected from published sources and recalculated to 2003 prices. Life-years gained were used as the measure of effectiveness, with QALYs gained as a sensitivity analysis. The perspective was that of the Swedish society with a separate analysis using a health care cost perspective. Costs and effects were discounted at 3%. **RESULTS:** The model predicts a net gain in survival of 0.04 years when adding clopidogrel. This comes at a net increased cost of 441€ if only direct costs are included. Including indirect costs, the net increase is reduced to 326€. The resulting cost-effectiveness ratio was 10,782€ and 7971€ per life-year gained for the different definitions of cost. Assuming a 0.1 reduction in utility following a MI, the cost per QALY gained was 6381€. Cost-effectiveness ratios were even lower in diabetics compared to non-diabetics. Results were robust to changes in discount rate and variations in unit costs. **CONCLUSIONS:** The predicted cost-effectiveness ratios are well below the threshold values generally considered cost-effective. Adding clopidogrel to ASA thus appears cost-effective in this indication.

PCV11

COST EFFECTIVENESS OF ADDING NIASPAN TO ATORVASTATIN TREATMENT IN THE SECONDARY PREVENTION OF CARDIOVASCULAR DISEASE IN PATIENTS WITH DYSLIPIDEMIA IN THE UK

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OBJECTIVES: High density lipoprotein-cholesterol (HDL-C) is inversely and independently associated with increased risk of cardiovascular disease (CVD). The importance of HDL-C as a risk factor for CVD is well accepted. We performed a modelling study to estimate the incremental cost per additional patient achieving target HDL-C (≥1 mmol/L) when Niaspan (extended release niacin) is added to stable statin therapy in CVD patients from the perspective of the National Health Service in the UK. **METHODS:** A 3-step probabilistic model was developed. Step 1: population of 10,000 patients with a normal distribution of lipid profiles defined by mean and standard deviation was created. Step 2: treatment effects of atorvastatin 10 mg were applied to the population and those whose low density lipoprotein-cholesterol (LDL-C) was satisfactory (≤3.0 mmol/L) but did not reach target HDL-C (≥1.0 mmol/L) received treatment with Niaspan. Step 3: treatment effects of Niaspan were applied in patients. Baseline lipid values and treatment effects were randomly sampled from distributions drawn from published epidemiological and clinical studies using second order Monte Carlo methodology. Cost for drugs and initiation of Niaspan treatment were taken from published sources. Results were presented for the initiation year, taking into account initiation costs and drop-outs, and maintenance year scenarios. **RESULTS:** In total, 16.3% of patients required Niaspan in addition to atorvastatin treatment to control dyslipidemia. Of these patients, 29.4% and 36.7% reached target HDL-C after addition of Niaspan in the initiation and maintenance years respectively. Additional costs in Niaspan treated patients were £320.30 and £252.30 for initiation and maintenance years respectively, leading to incremental costs of £1089 and £687 per additional patient achieving HDL-C target. **CONCLUSIONS:** The additional costs per patient treated to HDL-C target by adding Niaspan to statin therapy are comparable to those reported in the literature for treating patients with statins to LDL-C or total cholesterol targets.

PCV12

SECONDARY PREVENTION AFTER PCI: THE COST-EFFECTIVENESS OF FLUVASTATIN THERAPY IN THE NETHERLANDS

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OBJECTIVES: Little is known about the cost-effectiveness of secondary prevention after percutaneous coronary intervention (PCI). Aims of this study are to estimate 1) the cost-effectiveness of routine fluvastatin therapy after a first successful PCI in The Netherlands, and 2) the chance that fluvastatin therapy is cost-effective given a society's willingness to pay as laid down in Dutch guidelines. **METHODS:** A cost-effectiveness analysis was performed using data from the Lescol Intervention Prevention Study (LIPS). In the LIPS trial, patients with normal blood cholesterol to moderate hypercholesterolemia who had undergone a first PCI were randomized to receive either fluvastatin 40 mg twice-daily plus dietary counseling or dietary counseling alone. A Markov model (DataPro) was used to estimate the incremental costs per quality-adjusted life year (QALY) and life year gained (LYG). Costs were based on prices and reimbursed charges, utility data were drawn from literature. Hospital costs (admissions and procedures) were extracted from a database with complete national coverage. 10,000 Monte Carlo simulations and multivariate analysis were used to assess (2nd order) uncertainty. **RESULTS:** The mean net incremental costs of routine statin treatment were 734€ (SD: 686€) per patient over 10-years compared with controls. Treatment resulted in an incremental 0.078 (0.047) QALYs or 0.082 LYG (0.041). The incremental cost per QALY and LYG were 9312€ (14,648€) and 8954€ (16,617€) respectively. The sensitivity analysis revealed that the cost of fluvastatin and the discount rate had the largest effect on the ICER. Anticipating a willingness to pay of 20,000€ per QALY, there is a 75.1% chance that fluvastatin treatment is cost-effective. **CONCLUSIONS:** Statin therapy with fluvastatin