cost for acute period of MI at hospital was 25,340.00 rubles ($794.36) per patient. There was no significant difference between 3 hospitals. Median total cost for follow-up period in first 6 months after MI was 28,706.63 rubles ($899.89) per patient for services and drugs mentioned by experts. Median cost for second 6 months was 11,626.71 rubles ($364.47) per patient; each 6 months after it required 10,722.73 rubles ($336.14). CONCLUSION: Costs are relatively low because of rare use of expensive technologies: only 15% of patients received thrombolytical therapy; no coronary artery bypass surgery or stent implantation were used.

PCV39

MODELING THE ECONOMIC CONSEQUENCES OF IMPLANTING DUAL CHAMBER VS. SINGLE CHAMBER PACEMAKERS IN THE UK
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OBJECTIVE: To estimate the long-term economic and health impact of managing bradycardia due to sinoatrial node disease or atrioventricular block with a dual chamber (DDD or DDDR) vs. single-chamber ventricular pacemaker (VVI or VVIR).

METHODS: A discrete event simulation of 2 identical cohorts of 1000 patients for 5 years after implantation tracks development of post-operative complications, severe pacemaker syndrome leading to replacement, atrial fibrillation (which may become chronic and require anticoagulants), and stroke. Life expectancy is assumed the same with either device. Risk functions were developed for each device based on 2 long-term randomized trials (Canadian Trial of Physiologic Pacing, CTOPP and Mode Selection Trial in Sinus-Node Dysfunction, MOST). Sensitivity analyses were completed for key input parameters. Direct medical costs to the NHS are reported in 2003 British Pounds Sterling (GBP). Benefits were discounted at 1.5%, and costs 6%. RESULTS: Overall, 29.1% in each cohort died within 5 years of the implant. Post-operative complications requiring reoperation increased from 6.4% for VVI(R) to 7.7% with DDD(R), atrial fibrillation dropped from 22% to 18%; severe pacemaker symptoms developed in 16.8% with VVI(R) leading to a wish to switch to DDD(R). Total costs over 5 years were about 4300 GBP per patient in either cohort. Based on 100 replications, additional health benefits from DDD(R) are achieved with a mean net cost of 43 GBP per patient, and 0.09 QALY gained: a mean cost-effectiveness ratio of 477 GBP per QALY. In 26% of the replications, however, dual chamber dominates single chamber. CONCLUSIONS: Whilst implanting the DDDR(R) increases the cost of the initial implantation, this is offset by a reduction in long-term complications when compared with VVI(R).

PCV40

COSTS OF ISCHEMIC STROKE TREATMENT IN RUSSIAN FEDERATION
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OBJECTIVE: To calculate costs for patients with ischemic stroke (IS) in common medical practice in Russian Federation.

METHODS: Data on resource use for hospital treatment of patients with IS were extracted from 70 medical charts at 2 hospitals at Moscow. Data on resource use for out-patient follow-up for patients after acute myocardial infarction were identified according to experts’ opinion. Six experts filled in the questionnaire for identifying typical follow-up strategy for 1.5 years after MI. Direct medical costs were calculated on the basis of price-lists for medical services and median prices for drugs given in a wholesale pharmaceutical informational bulletin. RESULTS: Median cost for acute period of IS at hospital was 25,187.00 rubles ($789.56) per patient. There was some difference in costs between 2 hospitals, but no statistical significance was found. Computer tomography was performed only in 38% patients (mostly at one hospital). Median total cost for follow-up period in first 6 months after IS was 42,644.50 rubles ($1336.82) per patient for services and drugs mentioned by experts. Median cost for second 6 months was 13,561.08 rubles ($425.11) per patient; each 6 months after it required 9996.69 rubles ($313.38). CONCLUSIONS: According to experts’ opinion carotid endarterectomy is performed in no more than 10% patients after IS.

PCV41

COST-EFFECTIVENESS OF PHARMACEUTICAL TREATMENTS OF HYPERCHOLESTEROLEMIA IN CATALONIA, SPAIN
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OBJECTIVES: Pharmaceutical treatment of hypercholesterolemia is recommended in individuals with a LDL-cholesterol level of ≥190mg/dl and 130–189mg/dl plus two other coronary heart disease risk factors or a coronary heart disease risk >20% in 10 years. The objective of this study was to assess the cost-effectiveness of pharmaceutical treatments of hypercholesterolemia in Catalonia, Spain. METHODS: Treatments evaluated included 20, 40, and 80mg/day of lovastatin and fluvastatin, 10, 20, and 40mg/day of pravastatin, simvastatin and atorvastatin, 12 and 24g/day of cholestryamine, and 1.2g/day of gemfibrozil. The cost-effectiveness was evaluated comparing annual treatment costs and the percentage of LDL-cholesterol reduction. Treatment costs included medication, medical visits control measures, and treatment of secondary adverse effects. Wholesale prices in 2002 were used to estimate medication costs. A metaanalysis was carried out to estimate effectiveness of different treatments, including all published randomized, double blind clinical trials referred on Medline from 1991 to 2002. RESULTS: The annual cost of medication ranged from 332.98€ for 20mg/day lovastatin to 1105.17€ for 40mg/day atorvastatin. The percentage of LDL-cholesterol reduction ranged from 10% for 12g/day cholestramine to 49% for 80mg/day atorvastatin. The average cost-effectiveness ratios in terms of € per one percent of LDL-cholesterol reduced were 11.22€–22.55€ for atorvastatin, 12.00–21.96€ for simvastatin, 13.87–21.64€ for lovastatin, 15.24–24.69€ for fluvastatin, 20.96–41.77€ for pravastatin, 32.61€ for gemfibrozil, and 35.21–45.55€ for cholestramine. The incremental cost-effectiveness analysis showed that the more efficient cholesterol-lowering therapies were 10mg/day atorvastatin, 10mg/day simvastatin, 20mg/day lovastatin, 20mg/day fluvastatin, and 20, 40 and 80mg/day atorvastatin. CONCLUSIONS: Efficient statin therapies detected in this study should be the first election cholesterol-lowering drugs used in patients with hypercholesterolemia in Catalonia.

PCV42

PUBLIC HEALTH AND ECONOMIC IMPACTS OF RAISING THE LEGAL SMOKING AGE IN CALIFORNIA
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OBJECTIVE: Research has shown that most smokers start before the age of 18 and after that age the probability to start smoking decreases steadily. Furthermore, smokers who start earlier in life are less likely to quit and reducing or delaying initiation could have a large impact on public health. In 2002,