increased over the years; in 1996 13.7% of the patients started with at least an equipotent dose of four (simvastatin 20 mg or equipotent) while in 2004 88.4% of all patients started on at least an equipotent dose of four. Goal attainment increased from 42% in years prior to 2001 to 59% in 2002–2004 and was high in patients with cardiovascular disease and diabetes (43% versus 69%). CONCLUSIONS: Although in recent years aggressive statin treatment and lower baseline TC levels led to higher goal attainment 41% of the patients still did not reach goal. Therefore even more effective and well tolerated lipid lowering therapies seem to be required.

COST-EFFECTIVENESS OF ROSUVASTATIN IN THE PREVENTION OF ISCHEMIC HEART DISEASE IN PORTUGAL

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OBJECTIVES: To analyse the cost-effectiveness of Rosuvastatin compared to Atorvastatin in the treatment of hypercholesterolemia and prevention of ischemic heart disease (IHD) in Portugal. METHODS: A probabilistic Markov model was developed to analyse the costs and consequences of lifetime treatment with Rosuvastatin and Atorvastatin. For this purpose, results from head-to-head, randomised, double-blind trials evaluating low-density lipoprotein (LDL) changes and from a meta-analysis defining the relationship between LDL levels and fatal and non-fatal IHD events were combined. Incidence of myocardial infarction was derived from a nine-year Portuguese observational study. Death rates due to IHD and other causes were obtained from official data. Resource use in the treatment of MI was estimated by a Delphi panel of 8 Portuguese cardiologists with at least 15 years of clinical practice. Calculation of costs was done on both the societal and patients’ perspectives. Eligible population was defined as untreated individuals over 35 years of age with LDL above 160 mg/dl. RESULTS: Rosuvastatin slightly increases life expectancy: 5.64 days per patient and 8832 years for the eligible population. Although the drug is more expensive, economic analysis shows that Rosuvastatin is cost saving. It saves €105 or €57 per patient on the society’s or the patients’ perspective, respectively. Therefore, Rosuvastatin dominates the alternative having a cost-effectiveness ratio of −€6772 and −€3682 per life year according to the society’s or the patients’ perspectives. In the 10,000 simulations carried out Rosuvastatin was always more efficacious than Atorvastatin, being cost saving in 56.05% of the cases. If the willingness to pay is higher than €162 (society) or €98 (patients) Rosuvastatin is cost-effective in all cases. CONCLUSION: Rosuvastatin dominates Atorvastatin in the prevention of IHD in Portugal.

THE ECONOMIC ASSESSMENT OF SWITCHING TO DUAL INHIBITION CHOLESTEROL LOWERING THERAPY IN FINLAND

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While treatment guidelines recommend lowering cholesterol to target levels, many remain above recommended goal (TC >4.5 mmol/dl for CHD and diabetic patients). In a clinical trial patients switched from statin monotherapy to Ezetimibe/Simvastatin (dual inhibition therapy) experienced an additional 27.5% and an 18.8% reduction in LDL-C and TC, respectively. OBJECTIVE: Assess cost-effectiveness of switching patients to Ezetimibe/Simvastatin (followed by titration on Ezetimibe/Simvastatin) versus an atorvastatin dose titration strategy in CHD/diabetic patients who are not at goal with atorvastatin monotherapy. METHODS: Previously published decision-analytic model was used to project lifetime costs and benefits of lipid therapy. Clinical trial data were used in the model to estimate TC reductions for different treatment strategies. The effect of TC reductions on CHD event rates was estimated using Framingham equations and Finnish statistics on non-CHD-related mortality. Direct costs of CHD events in Finland [Health 2000 Survey data at the 2003 price level and also from the literature], Finnish prices for atorvastatin and Ezetimibe/Simvastatin and age specific quality-of-life weights were used to project cost/QALY. The model was run for a sample of Finnish CHD/diabetic patients (N = 25) that participated in the Finnish 2002 study and were not at TC goal while on therapy with atorvastatin and having data on all Framingham risk factors. RESULTS: The mean age of the study sample was 60.4 (SD 7.7) years, 60% male, lipid profile on atorvastatin TC 5.4 (SD 0.9) mmol/L, HDL-C 1.3 (SD 0.3) mmol/L, triglycerides 1.8 (SD1.1) mmol/L. Switching to Ezetimibe/Simvastatin (followed by 11% titration on Ezetimibe/Simvastatin) compared to atorvastatin titration (11%) is projected to increase undiscounted life expectancy by 0.75 years for CHD/diabetic patients with a discounted incremental cost/QALY of €9172. CONCLUSION: Switching to dual inhibition therapy, (Ezetimibe/Simvastatin) in CHD/diabetic patients not at goal on atorvastatin is projected to be a cost-effective alternative to atorvastatin titration.