risk of future CHD events and life expectancies from the onset of CHD. Efficacy parameters came from a comparative Phase III trial—study 25. Demographic variables and economic variables (costs of initiating and maintaining cholesterol-lowering therapy; the costs of managing CHD events and the costs of the drug therapy) were taken from published sources or calculated from unit costs and and the frequency of use of different services. A base case analysis was constructed from the perspective of a 55-year-old male. Extensive sensitivity analysis was conducted by varying the discount rates, drug prices, maximum percentage of benefits that could be achieved, time delay in the onset of benefits, and restricting the analysis to 10 years to allow for lack of long-term adherence. **RESULTS:** The incremental life years saved for rosuvastatin, atorvastatin, simvastatin, and pravastatin compared to no treatment for a 55-year-old male with 5.5 TC/HDL cholesterol ratio were 0.40, 0.33, 0.32, and 0.26 respectively. The associated incremental costs were £2844, £2856, £3107, and £3889. Rosuvastatin dominated the three other statins in the primary prevention of CHD, for all ages and all cholesterol levels. Sensitivity analysis confirmed the results. **CONCLUSIONS:** In this quasi-Markov model, rosuvastatin was shown to be more cost-effective for the primary prevention of CHD events than atorvastatin, simvastatin, and pravastatin.

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COST EFFECTIVENESS OF ANTIHYPERTENSIVE THERAPY IN DIABETIC PATIENTS IN ITALY

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OBJECTIVE: There is evidence of substantial benefit in antihypertensive combination therapy in diabetic patients compared to monotherapy. We evaluated the combination of low dose cilazapril plus low dose doxazosin (Cz + Dx) versus high dose cilazapril (Cz) and versus high dose doxazosin (Dx) in hypertensive diabetic patients in Italy. **METHODS:** An incremental cost effectiveness analysis was conducted in the societal perspective, considering Health care and indirect costs of treating for 10 years a hypothetical cohort of 1000 male diabetics, aged 50–54 years with levels of systolic blood pressure (SBP) above 160 mmHg, with Cz + Dx vs Cz vs Dx. The effects of considered drugs in lowering blood pressure were derived from the study by Rachmani et al (Nephron, 1998). Effectiveness was assessed in terms of morbidity and mortality (life years gained—LYG) and quantified using the UKPDS-36 study (Adler et al, BMJ 2000). Costs are expressed in €2003. We report undiscounted analysis: an analysis conducted using a discount rate of 5% for both costs and effects led to similar results. **RESULTS:** Cz + Dx therapy showed greater efficacy in reducing SBP compared to both Cz and Dx, leading to lower morbidity and to 231 LYG in the Cz + Dx cohort compared to Cz and Dx alone. Overall cost was lower for the Cz + Dx (€61.7 millions) cohort compared to Cz (€74.1 millions) and Dx (€73.9 millions). **CONCLUSIONS:** combination therapy with low dose cilazapril plus low dose doxazosin dominates both high dose cilazapril and high dose doxazosin in hypertensive diabetic patients in Italy, as it is both less costly and more effective.

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ECONOMIC IMPACT OF SELECTED FIXED-COMBINATION ANGIOTENSIN-CONVERTING ENZYME INHIBITOR/CALCIUM CHANNEL BLOCKER ANTI-HYPERTENSIVES AMONG PATIENTS WITH DIABETES

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OBJECTIVES: Certain combination anti-hypertensives vary in their levels of potentially adverse metabolic effects in patients with comorbid diabetes. We examined the characteristics of patients initiating combination therapy and the effects of treatment choice on direct medical costs, using integrated medical and pharmacy claims data. **METHODS:** Patients with prior evidence of diabetes who were newly-treated for hypertension from January 1998 to March 2002 and continuously enrolled for at least 6 months before and after therapy initiation were selected. Patients were stratified by initial fixed combination treatment (trandolapril/verapamil [TV] vs. benazepril/amlodipine [BA]). One-year costs of care were examined following initiation of therapy; costs were categorized as cardiovascular-related and all other-related care. 95% confidence intervals for cost differences were calculated using nonparametric bootstrapping techniques. **RESULTS:** The mean age of the sample (n = 174) was 53 years; 47% were female. 22%, 6%, 6%, and 3% of patients had comorbid diagnoses of hyperlipidemia, cardiac arrhythmias, other ischemic heart disease, and myocardial infarction respectively during pre-treatment. Patients in the TV group had lower cardiovascular-related cost as compared to the BA group ($2311 vs. $2570, mean difference: –$259, 95% CI [–$2730, $1438]). Differences in cardiovascular-related cost were manifested primarily in the cardiovascular-related inpatient cost ($615 vs. $1,209 for TV and BA, respectively, mean difference: –$594, 95% CI [–$2900, $823]). All other-related costs were considerably lower in the TV group ($5006 vs. $6404, mean difference: –$1397, 95% CI [–$9491, $3669]). Patients in the TV group ($7,317) had lower overall costs as compared to the BA group ($8,974; mean difference –$1,656, 95% CI [–$12,657, $4,735]). **CONCLUSIONS:** Use of fixed combination trandolapril/verapamil therapy among patients with diabetes is associated with reduced direct medical costs in comparison to combination benazepril/amlodipine.