Cancer-specific quality of life dimension scores are significantly related to EuroQol-5D scores.

CARDIOVASCULAR DISEASE

COST-EFFECTIVENESS OF LIPID MODULATOR AGENTS
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OBJECTIVE: In an era of cost-conscientiousness and budgetary restraints, the cost-effectiveness of lipid modulator agents must be considered. The study objective was to evaluate the cost-effectiveness ratio of lipid modulator agents, based on the agent’s effects on total cholesterol/HDL-cholesterol ratio (TC/HDL-c) and on the cost of acquisition.

METHODS: The choice of TC/HDL-c for the efficacy criterion was dictated by the overwhelming evidence that it is the most predictive parameter in assessing CHD risk when compared to other lipid/lipoprotein levels or ratios. Also, the evidence supporting the crucial role played by HDL is demonstrated in several studies, among which are the Framingham Study, LRC-CPPT, MRFIT, and PRO-CAM. The cost of acquisition of each medication was obtained from the Quebec Provincial Formulary (Liste de Medicament—July 1996). The meta-analysis of each dose of each medication’s effects on TC/HDL was based on a search generating 456 publications, from which 124 met the appropriate criteria.

RESULTS: From these publications, on average, the population is 50.5 years old, with 62.5% males; the baseline TC/HDL is 7.3. The various doses of each medication were ranked into three categories of efficacy based on the percent decrease of the TC/HDL ratio: less than 20%, 20–30%, and greater than 30%.

CONCLUSION: In the most effective category, the medications which showed the best efficacy to cost ratio were fluvastatin 60 mg (20% decrease per $ per day) and micronized fenofibrate 200 mg (19% decrease per $ per day), and then simvastatin 20 mg (15% decrease per $ per day).

ADAPTING ECONOMIC ANALYSES FROM ONE COUNTRY TO ANOTHER: DO THE WOSCOPS UK FINDINGS HOLD IN BELGIUM?
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In a previous analysis, based on the West of Scotland Coronary Prevention Study (WOSCOPS), pravastatin was demonstrated to lower the risk of cardiovascular disease (CVD) in hypercholesterolemic men, at an economic efficiency that is not prohibitive overall from the perspective of the National Health Service in the UK. For these results to provide guidance to those who set policy in other jurisdictions, they must account for differences among healthcare systems.

OBJECTIVE: The applicability of these findings to the Belgian setting was investigated by integrating the WOSCOPS results and Belgian epidemiological, resource use, and cost data.

METHODS: The Belgian Interuniversity Research on Nutrition and Health data were used to evaluate the baseline risk factor distribution and to partially validate the CVD exponential regression model derived from WOSCOPS. The rates at which subjects move for the first time from health to CVD were calculated, assuming the relative efficacy for pravastatin observed in WOSCOPS. The number of such transitions avoided was valued in terms of cost savings to the Belgian healthcare system and life-years gained. Resource use and costs were primarily derived from diagnosis-related expenditure in a subset of Belgian hospitals. Belgian life table data were obtained and substituted for the Scottish data to account for differences in life expectancy.

RESULTS: The cost-effectiveness ratio remains well below USD 25,000 (BEF 37 = USD 1) per life-year gained, the bound typically considered as “moderate to strong evidence for adoption and appropriate utilization.”

CONCLUSION: Although the precise estimate depends on the specifics of the country, the variation does not have an impact on the treatment decision the initial study supports.

EFFICACY OF CARDIAC REHABILITATION THERAPY: A PROSPECTIVE MULTICENTER COHORT STUDY
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To determine the efficacy of cardiac inpatient rehabilitation therapy (RT), 2442 consecutive patients (78% male, age ~60 [±10 years], and 22% female, age ~65 [±10 years] in 18 rehabilitation centers were examined in the period from January to June 1997. The primary indications for RT were myocardial infarction (56%), PTCA (6%), and CABG (38%). RT was initiated 34 days (median) after the acute event. During hospitalization (26 ± 5 days), patients received standard health training and medical therapy. Diagnostic tests and standardized surveys were prospectively documented. The prevalence of conventionally defined cardiovascular risk factors at the start and end of the rehabilitation therapy is shown in the table below.