cluded drug acquisition, supply and labour costs (in 1998 Canadian dollars). **RESULTS:** Two days of IV therapy cost $57.48, $78.51 and $82.52, for azithromycin, erythromycin, and cefuroxime, respectively. The total cost of a 10-day course of therapy was $136.36 for azithromycin and $165.58 for cefuroxime ± erythromycin ($126.36 for cefuroxime alone and $208.07 for cefuroxime + erythromycin). Approximately 280 CAP patients were seen at our institution in 1996, translating into potential cost savings of $8,182 per year with azithromycin. **CONCLUSION:** Azithromycin IV/PO is a cost-effective alternative for in-patient treatment of CAP.

MANAGEMENT STRATEGIES FOR RIBAVIRIN-INDUCED HEMOLYTIC ANEMIA IN THE TREATMENT OF HEPATITIS C: CLINICAL AND ECONOMIC IMPLICATIONS

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OBJECTIVE: This study outlines the management strategy used to treat ribavirin-induced hemolytic anemia (RIHA) when used in combination therapy in the treatment of chronic hepatitis C (CHC). It also estimates the direct cost of treating RIHA per treatment course. **METHODS:** A systematic review of the literature (1991–1999) was conducted to abstract information on the frequency and management of RIHA in the treatment of CHC. Costs were obtained from a large private health insurance database from the state of Washington, and from Drug Topics Red Book. Decision analytic techniques were used to develop a model (base case) that estimated the cost of RIHA. Additionally, several one-way sensitivity analyses, best and worst cases, and two additional clinical scenarios were simulated with the model. **RESULTS:** RIHA occurs in approximately 8% of those treated for CHC. Standard of care dictates management by dosage reduction or discontinuation of the ribavirin component of therapy. The decrease in effectiveness of therapy, as a result of this reduction/discontinuation, has not been studied. We estimate the direct cost of treating RIHA at $170 per patient per 48-week treatment course. The cost ranges from $68 to $692 in the best and worst case scenarios, respectively. **CONCLUSIONS:** RIHA is an anticipated side effect of therapy for CHC. Management of RIHA is simple and effective, however its impact on overall treatment effectiveness is not known. The direct cost of treating RIHA is low, although the likely decrease in effectiveness may increase indirect costs over time, and deserves further study.

COST ANALYSIS OF CEFTRIAXONE VERSUS CEFTRIAXONE PLUS MACROLIDE TREATMENT FOR PATIENTS HOSPITALIZED WITH COMMUNITY-ACQUIRED PNEUMONIA (CAP)

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Pneumonia was the third leading admitting diagnosis at a large tertiary care hospital costing $12,653 per admission. The American Thoracic Society recommends the use of a -lactam with or without macrolide as the preferred antimicrobial regimen for patients with CAP admitted to a non-ICU. **OBJECTIVE:** The objective of this evaluation was to compare ceftriaxone alone (regimen 1) versus ceftriaxone plus macrolide (regimen 2) using length of stay, antibiotic costs, and total hospital charges from a hospital perspective. **METHODS:** The data were collected prospectively during December 1998 and May 1999. Fine et al 1998 defined risk scores for CAP and classified them into 5 categories: 1 (low risk) through 5 (high risk). Most of our patient population belonged to risk class 2. We compared 26 patients diagnosed with CAP and stratified into risk class 2. Thirteen patients received regimen 1 and 13 patients received regimen 2. **RESULTS:** We found statistically significant differences in hospital length of stay, antibiotic costs, and total hospital charges. Patients who received ceftriaxone alone had shorter lengths of stay (2.7 ± 1.9 days vs. 5.6 ± 3.9 days, $P = 0.028$), lower antibiotic costs ($93.02 ± $58.79 vs. $169.11 ± $108.81, $P = 0.036$), and lower total hospital charges per patient ($2,362.41 ± $1,442.18 vs. $4,431.42 ± $3,108.92, $P = 0.040$) than patients who received ceftriaxone plus macrolide. **CONCLUSION:** Ceftriaxone alone may be sufficient in the treatment of hospitalized CAP patients who are classified in risk class 2.

A MULTINATIONAL PHARMACOECONOMIC EVALUATION OF THE SEVEN-VALENT PNEUMOCOCCAL CONJUGATE VACCINE

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The seven-valent pneumococcal conjugate vaccine (PCV) is the only vaccine to immunize children under two years old against *Streptococcus Pneumoniae*, a leading cause of meningitis, bacteremia, pneumonia, otitis media, and sinusitis. **OBJECTIVE:** The purpose of this analysis is to assess the cost-effectiveness of PCV in Canada, the United Kingdom, France, Germany, Italy, and Spain. **METHODS:** A Markov cohort simulation model was constructed to compare the health and economic outcomes of children vaccinated with PCV versus unvaccinated. Estimated disease-specific incidence and mortality