PCV59  
ANNUAL MEDICAL EXPENDITURE AND MORTALITY RELATED TO ACUTE CORONARY SYNDROME (ACS) IN THE UNITED KINGDOM – A SYSTEMATIC REVIEW  
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OBJECTIVES: Overall expenditure for the treatment of ACS imposes a heavy burden on global health care systems. As new treatments and procedures have become available in the past decade, the cost to healthcare systems has increased, yet mortality rates have remained relatively high. A recent research effort was undertaken to benchmark expenditures and outcomes in patients with ACS. The aim of this study was to understand the efficiency of resource use, in relation to mortality for patients with ACS in the UK. METHODS: A systematic literature search for 11 databases and secondary desk research were performed to identify ACS related expenditure and outcomes. Data were retrieved for UK patients with MI (STEMI, NSTEMI) and unstable angina. The reported cost data were extracted for investigations, procedures, pharmaceutical treatment, and monitoring; mean annual expenditure per patient was estimated based on the cost of these components. Outcomes focused on ACS mortality rate over the entire UK population. RESULTS: In the UK, the overall annual mortality rate for ACS was found to be 0.0473%. Total annual expenditure for all patients with ACS was £392,245,277 (£3,733 per patient). Results showed hospitalizations to be the main cost driver, accounting for 65.7% of the total cost. Resource utilization and monitoring costs accounted for 4.5% and 4.5%, respectively. CONCLUSIONS: The findings of this systematic review demonstrate that hospitalization cost accounts for almost two thirds of the total direct cost associated with ACS in the UK. More research and cross-country comparisons are needed to determine strategies which provide greater efficiency in resource use for the management of ACS.  

PCV60  
COST-EFFECTIVENESS OF DABIGATRAN FOR THE PREVENTION OF STROKE IN PATIENTS WITH NON-VALVULAR ATRIAL FIBRILLATION IN AUSTRALIA  
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OBJECTIVES: The objective of this cost-utility analysis was to compare the costs and effectiveness (DV / QALY) of dabigatran, adjusted dose warfarin (WAR), aspirin (ASP) or no treatment (UNT) in patients with Non-Valvular Atrial Fibrillation (NVAF), from the perspective of the third party payer in the Australian public healthcare system. METHODS: A Markov cohort model was constructed based on the pivotal RE-LY clinical trial and indirect comparisons with aspirin treatment and no treatment. The model calculated the incremental cost per QALY of different dabigatran treatment groups compared to aspirin (aspirin plus warfarin if current medication. The cost of all drugs was assumed to be the official price. Data for costs were derived from the publicly available tendering information in NSW, Australia. Resource use was modelled until the patient died or was last observed. RESULTS: dabigatran was associated with greater life years per QALY (5.30 vs 5.19) compared to aspirin and UNT, which were associated with similar life years per QALY (5.19 and 5.14). The QALYs gained by dabigatran treatment were associated with a greater cost compared to aspirin treatment (€3,787, 95% CI €3,366–€4,166) and UNT (€4,270, 95% CI €3,855–€4,694). The most relevant categories of costs were inpatient hospitalization (€960, 95% CI, €574-€4,437), 61.6% of direct hospital costs, specific therapeutic interventions (€984, 95% CI, €783–€1,185, 15.3%), imaging tests (€951, 95% CI, €878–€1,024, 14.8%), medication (€302, 95% CI, €209–€394, 4.7%). Laboratory tests (€145, 95% CI, €126–€164, 2.3%), and supporting therapeutic interventions (€145, 95% CI, €126–€164, 2.3%). CONCLUSIONS: The cost-burden of stroke in Spain is substantial because of long hospital stays and other health resource utilization. Results from this study show higher costs than previously published data.  

PCV62  
INFLUENCE OF SMOKING ON THE USE OF HEALTH-CARE RESOURCES AND COSTS IN PATIENTS WITH CARDIOVASCULAR DISEASE  
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OBJECTIVES: To determine the effect of the use of tobacco in the consumption of health care resources and their associated costs in patients who have suffered some kind of cardiovascular event (CVE) in a populational scope. METHODS: Multicentric observational study undertaken through the retrospective review of the medical histories of patients at primary care and/or specialized consultations. Inclusion criteria: subjects>30years, who requested health care after suffering a CVE between 2003 and 2007. Follow-up: 36 months. Groups: smokers, ex-smokers and non-smokers. Variables: Main measures: sociodemographics, comorbidities, number of consultations and total costs [primary health care consultations and productivity losses [absenteeism days]] Statistical analysis: logistic regression model and ANCOVA (procedure: marginal means; adjustment: Bonferroni). p<0.05. RESULTS: A total of 2540 patients fulfilled the inclusion criteria (smokers: 8.4%, ex-smokers: 52.9%, non-smokers: 38.7%). Mean age: 68.1 years old; men: 50.7%; body mass index (BMI) with addition of BMI and waist circumference (WC) in overweight patients. 74.8% of patients presented with hypertension (HT), 59.8% with hypercholesterolemia (HC), 43.6% with diabetes mellitus (DM), 45.2% with atrial fibrillation (AF) and 11.57, 5% with current smoking. CONCLUSIONS: Smoking habits could lead to a greater consumption of health care resources and an increase in costs, and therefore could be considered a determinant factor of the overall health care costs.  

PCV63  
DIRECT HEALTH CARE COSTS OF ORAL ANTICOAGULANT TREATMENT IN PATIENTS WITH NON VALVULAR ATRIAL FIBRILLATION  
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OBJECTIVES: To quantify direct health care costs of oral vitamin K antagonist anticoagulant treatment in patients diagnosed with non valvular atrial fibrillation (NVAF). We examine whether a correlation exists between poor INR control and direct medical costs. METHODS: We designed an observational study. We re- vised the clinical histories of patients diagnosed with NVAF and treated with OATs at the Fundación Jiménez Díaz (FJD) between 01/10/2009 and 30/09/2010 (N=1,257). We collected INR value, number of visits due to INR control, type of anticoagulant (warfarin or acenocoumarol), hospital admissions due to complications and other current medication. The cost of all drugs was assumed to be the official price. Expenditure in INR control was calculated using the costs of all health care resources involved in the procedure. We used DRGs for the cost of each hospitalisation. The cost of a hospital visit was calculated using four scenarios, using actual invoices or using analytical accountancy methods. All costs are expressed in 2010 euros. RESULTS: The average cost per patient was €630.98. Costs were higher among smokers in comparison with ex-smokers and non-smokers (€7,980.70 versus €7,322.10 and €5,618.90; p<0.001), in terms of both health-care costs (€6,272.90 versus €5,672.50 and €4,822.90; p<0.001) and losses of productivity at work (€1,707.70 versus €1,649.60 and €796.00; p<0.001), respectively. CONCLUSIONS: In routine clinical practice, smokers patients compared to ex-smokers and non-smokers, show a higher cost from a societal perspective, both in health care related costs and in labour productivity losses.  

PCV64  
ARE HOSPITAL COSTS FOR STROKE UNDERESTIMATED IN SPAIN?  
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OBJECTIVES: To estimate the costs for the first clinically diagnosed stroke, in Spain. METHODS: Observational prospective study conducted in 16 Spanish hospitals (CONOCES study. Costes Socioeconómicos del Ictus en España). Patients will be needed to determine treatment strategies which provide greater efficiency in resource use for the management of ACS.  

OUTCOMES: The results of this study are anticipated to provide valuable insights into the cost-effectiveness of dabigatran for the prevention of stroke in a real-world setting. The findings suggest that dabigatran offers a cost-effective alternative to traditional anticoagulant therapies for the prevention of stroke in patients with NVAF. The study also highlights the importance of improving INR control to reduce the economic burden associated with stroke prevention. These findings are crucial for health policy makers and healthcare providers in making informed decisions about the appropriate use of dabigatran and other antithrombotic agents.