base-case analysis. RESULTS: Base case analysis, resulted in an ICER of £15,681 per QALY for EVAR versus OSR. The average QALY gain at 30 years post surgery was 0.072 for EVAR compared with OSR. Results were most sensitive to the relative risk of short-term mortality, cost of the EVAR device and long-term rate of secondary interventions in the EVAR group. CONCLUSIONS: The results suggest that EVAR is cost-effective for non-ruptured AAA versus OSR with a probability of 66% and 60% based on willingness-to-pay thresholds of £30,000 and £20,000, respectively.

PCV70

COST-EFFECTIVENESS OF CLOPIDOGREL IN COMBINATION WITH ASPIRIN FOR ACUTE CORONARY SYNDROMES IN AUSTRALIA

Liew D1, Cordony A2
1The University of Melbourne, Melbourne, Victoria, Australia, 2Sanofi-Aventis Australia, Macquarie Park, NSW, Australia

OBJECTIVES: To determine if clopidogrel plus aspirin is cost-effective compared to aspirin alone for patients following ACS, from the Australian health care perspective. METHODS: A Markov model was constructed by extrapolation of data from the Australian Acute Coronary Syndromes Prospective Audit (ACACIA) registry (n = 2,553) in the first model cycle, and the Reduction in Atherothrombosis for Continued Health (REACH) registry (n = 2,567 Australian patients) in subsequent cycles. Decision analysis was applied to compare clopidogrel plus aspirin against aspirin alone. Efficacy data were drawn from the Clopidogrel in Unstable Angina to Prevent Recurrent Events (CURE) trial. A utility study was conducted in 2007 with 86 participants using health states validated by clinical experts. Drug and disease costs were obtained from literature and health care reimbursement fees, and updated using Australian health price indices. An annual discount rate of 5% was applied to all costs and effects beyond one year in accordance with reimbursement guidelines. Twenty sensitivity analyses were undertaken, varying the 95% confidence intervals surrounding efficacy measures from CURE, uncertainty in cost and utility inputs and variations to time horizons and discount rates. RESULTS: The base-case incremental cost-effectiveness ratio (ICER) with a ten-year time horizon was A$14,496/QALY and A$40,000/QALY throughout all sensitivity analyses. Treatment remained cost-effective up to an inflated clopidogrel cost of A$40,267/QALY. The five-year ICER was A$20,124/QALY. Sensitivity analyses demonstrated that the ICER ranged from A$6,443/QALY when the risk of events observed in ACACIA were applied to all years, up to A$36,974/QALY using the 95% upper confidence interval for efficacy. CONCLUSIONS: Clopidogrel with aspirin represents a highly cost-effective treatment option for patients with ACS in Australia. This was confirmed by the Australian reimbursement authority’s recent recommendation that treatment with clopidogrel plus aspirin be reimbursed for ACS patients.

PCV71

COST-UTILITY ANALYSIS IN PATIENTS WITH DRUG REFRACTORY CONCOMITANT ATRIAL FIBRILLATION IN SPAIN

López Gude M1, Rodríguez Bezos D2, Rodríguez Barrios JM1, Serrano Contreras D1
1Hospital 12 Octubre, Madrid, Spain, 2Medtronic Iberia, Madrid, Spain

OBJECTIVES: Atrial fibrillation is the most common arrhythmia in the clinical practice. It is related with an important morbidity, a decrease in patients’ quality of life and is a risk factor of suffering a stroke. The Spanish estimated atrial fibrillation prevalence is 2.52%, and is higher over 60 years. Radiofrequency surgical ablation is a treatment alternative to restore sinus rhythm in drug-refractory atrial fibrillation patients. The main objective of this study is to develop a five-year cost-utility analysis including the different treatment alternatives in drug-refractory concomitant atrial fibrillation patients in the Spanish setting. METHODS: A Markov model was developed to simulate the evolution of a 1000 cohort of over 40 years old patients with paroxysmal and persistent atrial fibrillation that could be treated with: non-ablation, surgical ablation and catheter ablation. The model included four health states: sinus rhythm, atrial fibrillation, dependent stroke and death. The time horizon was five years, with a cycle length of three months. The data of cost and effects were obtained from the published literature and experts opinion. Costs and effects were discounted at 3.5%. A sensitivity analysis was developed to determine the robustness of the main variables of the model. RESULTS: Based on 1000 patients simulation with concomitant atrial fibrillation, preliminary results show that the QALY gained were 3.79, 4.25, and 4.23, respectively for no ablation, surgical ablation and catheter ablation. The costs per patient were respectively 8889, 11,137 and 11,865. The cost per QALY gained of the most effectiveness option (surgical ablation) when compared with no ablation is €4909. Surgical ablation is a dominant option vs. catheter ablation. CONCLUSIONS: These preliminary results show that surgical ablation is a cost-effective treatment option in drug refractory concomitant atrial fibrillation patients in the Spanish setting, with less cost and a higher efficacy than the catheter ablation.

PCV72

COST/UTILITY ANALYSIS (CUA) OF VALSARTAN FOR THE TREATMENT OF CONGESTIVE HEART FAILURE (CHF) IN ITALY BASED ON THE VAL-HEFT TRIAL

Pradelli L, Iannazzo S, Zaniolo O
AdRes Srl, Turin, Italy

OBJECTIVES: CUA of the use of valsartan when added to standard treatment in CHF management in Italy. METHODS: A probabilistic Markov model, made up of states corresponding to NYHA classes II, III, IV, and death, was developed in WinBUGS to apply findings from the Val-HeFT Trial to the Italian setting. Simulation lasts 10 years, divided in 1-month cycles. Transition probabilities represent individual mortality, derived from the general population mortality by gender and age multiplied by a NYHA state-specific HR, and probability of changing NYHA class, derived from Val-HeFT. The model is informed with NYHA state- and age-specific utilities and hospitalization probabilities (adjusted for gender and ACEi-use). Costs are calculated in the perspective of the Italian NHS and account for drugs and CHF hospitalizations. The cohort was defined to represent Italian patients with mild-to-severe CHF and LVEF < 40% over 45 years (Val-HeFT inclusion criteria). Results were calculated through 30,000 iterations of the patient-level simulation (each individual is created by drawing from age, gender and ACE-I use distributions of the cohort). Annual discount rate of 3.5% was applied to costs and health outcomes. Uncertainty around model parameters was handled by probabilistic sensitivity analysis (PSA), performed by simultaneous drawing of each model parameter from the original data source 95% CI, or from the +/- 10% range where original CI was unavailable. RESULTS: On average, in the simulation timeframe patients live 4.4 years (32 QALYs), with a slight increase in the valsartan group, in which costs are reduced by approximately €500/pt. In subgroup