avoided versus ENOX was quantified using a modelling approach based on decision-tree technique synthesising published data and a hospital survey. Safety and efficacy values of VTE prevention with the comparators were taken from the EPHEMUS [Lassen et al. Lancet 2002], PENTAMAKS [Bauer et al. NEJM 2001] and PENTHIFRA [Eriksson et al. NEJM 2001] trials. Data on resource utilization (staff, drugs, materials, laboratory, and equipment) during thromboprophylaxis, diagnosis and treatment came from the hospital survey. Resources were valued in internal hospital prices as of the first quarter of 2007. The evaluation exclusively encompassed inpatient days for thromboprophylaxis and treatment of VTE and major bleed during the MOSLL-related hospital stay. RESULTS: In the base-case analysis, FOND dominated ENOX: cost savings of €3430 were obtained and 11.8 clinical VTE were avoided by FOND versus ENOX, each per 1000 patients. In comprehensive sensitivity analyses, using impact analysis and Monte Carlo simulation, the robustness of these results was tested. The rate of prophylaxis-related bleeding with FOND (RPBF) had the greatest impact on the savings. FOND remained cost-saving in 61% and 77% of 10,000 iterations with the first FOND injection 6 hours after surgical closure (RPBF = 0.028) or the morning after surgery (RPBF = 0.019), respectively. FOND remained more effective than ENOX without exception: after 10,000 iterations, between 4.6 and 21.2 clinical VTE were avoided by FOND versus ENOX per 1000 patients. CONCLUSION: FOND offers hospitals in Germany a clinically and economically advantageous alternative for prevention and treatment of VTE in patients undergoing MOSLL.

**CV6**

**SIROLIMUS-ELUTING VERSUS BARE-METAL CORONARY STENTS: 18-MONTH CLINICAL AND ECONOMIC OUTCOMES OF A CONTROLLED STUDY FOR THE REDUCTION OF CORONARY RESTENOSIS**

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**OBJECTIVES:** To evaluate the long-term outcomes of serolimus-eluting stents (SES) in comparison to bare-metal stents (BMS) in elective treatment of coronary artery disease (CAD).

**METHODS:** In the prospective GERSHWIN study in 35 hospitals in Germany, CAD patients undergoing percutaneous coronary intervention (PCI) were electively treated with SES or BMS (sequential control design with a case:control ratio of 2:1). Standardized questionnaires completed by patients and physicians at 3, 6, 12, and 18 months following PCI documented major adverse coronary events (MACE), including death, myocardial infarction, coronary artery bypass surgery and re-PCI in target vessel, as well as disease-related direct and indirect costs. RESULTS: From April 2003 until June 2005, 658 patients were treated with SES (87% male, mean age 63 ± 9) and 294 patients with BMS (79% male, mean age 64 ± 10). SES was documented in 34% SES patients and 29% SES patients. After 18 months, 8% of SES and 25% of BMS patients with SV had suffered MACE in comparison to 15% of SES and 19% of BMS patients with MVD, indicating a difference in the effect of SES with respect to the underlying CAD status (p adjusted = 0.023). In SVD, SES and BMS incurred total costs of EUR 11,832 and 12,399, respectively. In MVD, SES and BMS incurred total costs of EUR 14,964 and 12,026, respectively (p adjusted = 0.003). In patients with MVD, the cost-effectiveness of SES was EUR 12,805 per patient free from MACE compared to EUR 16,488 in BMS. In patients with MVD, the cost-effectiveness of SES was EUR 17,522 per patient free from MACE compared to EUR 14,810 in BMS. CONCLUSION: In patients with SVD, SES is more cost effective than BMS whereas in patients with MVD, SES is less cost effective than BMS.

**CV7**

**COMPARISON OF THE COST-EFFECTIVENESS OF SEROLIMUS-ELUTING VERSUS BARE-METAL STENTS IN RELATION TO PATIENT CORONARY ARTERY DISEASE STATUS**

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**OBJECTIVES:** To evaluate the cost-effectiveness of serolimus-eluting stents (SES) to bare-metal stents (BMS) in patients with single-vessel coronary artery disease (SVD) compared with patients with multi-vessel disease (MVD). METHODS: In the prospective GERSHWIN study in 35 hospitals in Germany, patients with coronary artery disease (CAD) undergoing percutaneous coronary intervention (PCI) were electively treated with SES or BMS (sequential control design). Standardized questionnaires completed by patients and physicians through 18 months following PCI documented major adverse coronary events (MACE), including death, myocardial infarction, coronary artery bypass surgery and re-PCI in target vessel, as well as disease-related direct and indirect costs. RESULTS: From April 2003 until June 2005, 658 patients were treated with SES (87% male, mean age 63 ± 9) and 294 patients with BMS (79% male, mean age 64 ± 10). SES was documented in 34% BMS patients and 29% SES patients. After 18 months, 8% of SES and 25% of BMS patients with SV had suffered MACE in comparison to 15% of SES and 19% of BMS patients with MVD, indicating a difference in the effect of SES with respect to the underlying CAD status (p adjusted = 0.023). In SVD, SES and BMS incurred total costs of EUR 11,832 and 12,399, respectively. In MVD, SES and BMS incurred total costs of EUR 14,964 and 12,026, respectively (p adjusted = 0.003). In patients with MVD, the cost-effectiveness of SES was EUR 12,805 per patient free from MACE compared to EUR 16,488 in BMS. In patients with MVD, the cost-effectiveness of SES was EUR 17,522 per patient free from MACE compared to EUR 14,810 in BMS. CONCLUSION: In patients with SVD, SES is more cost effective than BMS whereas in patients with MVD, SES is less cost effective than BMS.

**CV8**

**THE COST-EFFECTIVENESS (COST-UTILITY) OF EPROSARTAN IN HYPERTENSIVE PATIENTS WITH CEREBROVASCULAR DISEASE IN BELGIUM, GERMANY, SPAIN, UNITED KINGDOM, AND SWEDEN**

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**OBJECTIVES:** The purpose of this study was to evaluate the relative cost-effectiveness (cost-utility) of the angiotensin II antagonist eprosartan versus other antihypertensives (nitrindipine, perindopril, enalapril) in a secondary prevention setting (hypertensives with cerebrovascular disease at baseline) in Belgium, Germany, Spain, UK and Sweden. METHODS: The HEALTH model (Health Economic Assessment of Life with Tekvena® for Hypertension) is an object-oriented probabilistic Monte Carlo simulation model. It combines a Framingham-based risk calculation with a systolic blood pressure approach to estimate the relative risk reduction of cardiovascular and cerebrovascular events based on recent meta-analyses. For eprosartan an additional risk reduction was modelled according to the results of the MOSES study (Morbidity and Mortality after
**Controlled Trial**

**Objective:** To examine in randomized controlled trial the effectiveness and cost-effectiveness of arthroscopic acromioplasty in the treatment of stage II shoulder impingement syndrome.

**Methods:** We divided 140 patients into supervised exercise program (n = 70, exercise group) and arthroscopic acromioplasty, followed by a similar exercise program (n = 70, combined treatment group). The primary health outcome measure was self-reported pain on a 0–10 Visual Analogue Scale at 24 months with a two-point change defined as minimal clinically important difference (MCID).

**Results:** Results in an intention-to-treat analysis an improvement exceeding MCID took place from baseline to 24 months in both groups: self-reported pain diminished from 6.5 to 2.9 in the exercise group (N = 66) and from 6.4 to 2.5 in the combined treatment group (n = 68) (P < 0.001 in both). In the combined treatment group pain relief was attained faster, but the groups did not any more differ at 24 months (P = 0.37). A similar pattern was seen in the secondary outcome measures: disability, pain at night, SDQ score, ability to work, number of painful days and proportion of pain-free patients. The mean total cost was €2961 in the combined treatment group and €1864 in the exercise group. The incremental cost-effectiveness ratio was €5852 per MCID unit, i.e., combined treatment was considerably more costly.

**Conclusion:** Arthroscopic acromioplasty does not provide any significant additional value over structured and supervised exercise program alone in terms of subjective outcome or cost-effectiveness. Operative treatment should be offered judiciously.