OBJECTIVES: To compare the direct medical costs associated with two different regimens for the treatment of Helicobacter pylori-related peptic ulcer disease (PUD) from a hospital perspective. The efficacy of a new regimen, including ranitidine bismuth citrate, amoxycillin and clarithromycin (RAC), was recently compared in a study at a local teaching hospital with that of a regimen consisting of omeprazole, amoxycillin and clarithromycin (OAC). The study results showed no significant difference in the efficacy of the two regimens, but the cost implication of the two regimens was not examined. The drug cost of OAC (HK$364, $US = 7.8HK) was 20% more than that of RAC (HK$304) for a 7-day therapy.
METHOD: Data from a controlled, randomized clinical trial conducted in Hong Kong was reanalyzed. The records of 100 patients with Helicobacter pylori-related PUD, who were previously randomized to receive either RAC or OAC, were reviewed. The hospital resources consumed during the period of PUD treatment were retrieved and studied. The total cost associated with each regimen per ulcer-healed patient was calculated and analyzed.
RESULTS: Twelve of the 100 patients were excluded from the analysis because of incomplete documentation or noncompliance with the protocol of the clinical trial. Forty-one inpatients and 47 outpatients were included in the analysis. In the inpatient group, there was no significant difference between the median direct cost associated with OAC and RAC ($13,042 and $11,622, respectively; P = 0.168). In the outpatient group, the median direct cost associated with RAC was significantly lower than that of OAC ($4,096 and $3,839, respectively; P = 0.003).
CONCLUSION: The direct medical costs associated with OAC and RAC were similar for inpatient treatment of Helicobacter pylori-related PUD but RAC was less costly in the outpatient setting.

TPC3

COST OF AML TREATMENT IN BELGIUM: RESULTS OF A RANDOMIZED TRIAL WITH AND WITHOUT FILGRASTIM USE

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INTRODUCTION: A randomised multi-centre phase III trial using Filgrastim (5 μg/kg/day until neutrophil recovery) in induction and consolidation therapy for 'de novo' adult acute myeloid leukaemia (AML) patients showed safety and efficacy of the drug with significant reduction in hospital duration and IV anti-infective drug therapy (Heil et al, Blood, 1997, 90, 4710–4718).
OBJECTIVE: Considering the Belgium patients enrolled in the trial to estimate the financial impact of Filgrastim use in the treatment of AML for that country.
METHODS: Retrospective data collection of resource use was obtained from the 36 Belgian patients (20 cases and 16 controls) enrolled through 3 hospitals. The data were retrieved from Case Report Forms and hospital bills. The cost perspective considered is the reimbursement authority of Belgium. A cost-minimisation model is developed including the following resource items: hospital duration, IV anti-infective drug days, lab test days, blood transfusion units, vials of Filgrastim, other drug use excluding chemotherapy, and use of other diagnostic tests (Rx, Scans). Unit costs in 1998 BEF are retrieved from the reimbursement authority (RIZIV/INAMI), the Red Cross Blood Bank, the database of the Belgium Pharmaceutical Association (APB), and a private database on cost of health care in Belgium hospitals (CECODI).
RESULTS: The cost model shows an average cost decrease of 73.31 BEF (5,7%) per patient for induction and consolidation therapy with Filgrastim. Sensitivity analysis on hospital day costs that may widely vary, shows a break-even point reached at a cost per day much lower than the minimum reimbursement cost (break-even point = 952 BEF).
CONCLUSIONS: Filgrastim use in the treatment of AML patients in Belgium is likely to induce cost savings. The cost results are conservative estimates that do not include indirect cost evaluations and quality of life improvement of the patient due to earlier hospital discharge.

TPC4

AN ECONOMIC EVALUATION OF AMLODIPINE FOR THE TREATMENT OF NONISCHEMIC DILATED CARDIOMYOPATHY: THE PROSPECTIVE RANDOMIZED AMLODIPINE SURVIVAL EVALUATION (PRAISE)

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OBJECTIVE: To evaluate the economic implications of amlodipine therapy in patients with advanced left ventricular dysfunction due to nonischemic dilated cardiomyopathy by using data from the Prospective Randomized Amlodipine Survival Evaluation (PRAISE).
METHODS: By using a decision analytic model, costs and effects were estimated for the first 2 years of observation in PRAISE and were projected for 30 years after initiation of therapy (referred to as the lifetime projection).
RESULTS: While statistical tests of the survival curves indicated that amlodipine significantly improved survival ($P < 0.001$), differences in life expectancy (amlodipine, +0.19 years (95% CI, −0.03 to 0.41 years during the first 2 years of the trial; +2.89 years, 95% CI, −0.37 to 6.14 years projected for the patient's lifetime) were not significant. The ratios of cost per year of life saved were <$8000; those of cost per quality-adjusted year of life saved were <$14,300. The confidence intervals for the cost-effectiveness ratios indicated that for the first 2 years of the trial, amlodipine was unlikely to have ratios