differences to be much higher than median differences. Regression analysis explained about 40% of the cost variance and indicated no significant total cost differences between therapies. Clinically evaluable sample results were qualitatively similar to the ITT sample. CONCLUSION: Substantial variation in hospital costs in this moderately large multinational Phase-3 trial does not allow definitive conclusions regarding whether the length of stay differences seen earlier result in total treatment cost differences. In future research, combining data with other similar trials may allow for more precise point estimates of cost differences.

**PHARMACOECOENOMIC ANALYSIS OF ACUTE EXACERBATION OF CHRONIC BRONCHITIS TREATMENT WITH TELITHROMYCIN OR CEFUROXIME-AXETIL**

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**OBJECTIVE:** A pharmacoeconomic analysis was carried out comparing the efficiency of two treatment options for acute exacerbation of chronic bronchitis (AECB): Telithromycin and Cefuroxime-axetil. METHODS: Retrospective analysis using a decision tree model. The efficacy of the 2 treatment options was estimated from a randomised, double-blind clinical trial, in which 800mg/day (5 days) of Telithromycin was compared to 1,000mg/day (10 days) of Cefuroxime-axetil in patients with AECB (140 and 142 respectively). The utilisation of resources was estimated from the clinical trial and Spanish sources, and the unit costs from a Spanish health costs database. Costs were evaluated for the acquisition of antibiotic treatments, change of antibiotic due to therapeutic failure, hospital admissions, adverse reactions treatment, primary care visits, tests and indirect costs (working days lost). The model was validated by a panel of Spanish clinical experts. RESULTS: As the clinical trial was designed to show equivalence, there were no significant differences in efficacy between the treatment options (clinical cure rate 86.4% and 83.1% respectively), and a cost minimisation analysis was performed. In the base case, the average cost of the disease per patient was €174.83 with Telithromycin and €194.68 with Cefuroxime-axetil (a difference of €19.85). The results were stable in the sensitivity analysis, with differences favourable to Telithromycin ranging between €18.04 and €22.25. CONCLUSIONS: Telithromycin results in a cost saving of up to €22 per patient with AECB compared to Cefuroxime-axetil.

**FIVE-YEAR BUDGET IMPACT AND LIFETIME COST EFFECTIVENESS OF A LOPINAVIR/RITONAVIR (LPV/r) VS. A NELFINAVIR (NFV) CONTAINING REGIMEN FOR TREATMENT-NAÏVE PATIENTS**

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**OBJECTIVES:** Clinical trials of antiretroviral (ARV) regimens are too short to allow a long-term assessment of economic and quality of life differences for competing regimens. However, surrogate marker data from ARV trials used in a long-term mathematical model that incorporates epidemiologic and economic data, and current treatment patterns, can be used to estimate long-term costs and outcome differences. This study compares long-term health outcomes and cost effectiveness of LPV/r vs. NFV regimens in treatment-naïve patients. METHODS: We developed a new generation three-compartment Markov model with a combination of viral load and CD4 count as surrogate markers compared to the previous generation model using only CD4 count as a surrogate marker. The model applied epidemiologic data from 5,000 patients on HAART therapy, cost data from 2,000 U.S. Medicaid patients, and quality of life data from 21,000 HIV-patient responses to the EQ5D. The model's predictive ability was tested against published HAART study data, and on data from 1,456 HIV U.S. patients in 70 primary care practices. Into this validated model we inserted the study VL and CD4 count data (ITT missing = fail) from the 48-week analysis of the ABT-M98-863 clinical trial. RESULTS: The model estimated a $4,011 per patient cost savings in favor of the LPV/r regimen, when budget impacts were compared over the first 5 years. The incremental cost effectiveness ratio was $3,423/QALY for LPV/r vs. NFV, and an improvement in median survival of 24 QALYs for a cohort of 100 patients was found. This cost effectiveness ratio is comparable to values for generic blood pressure control medications. The results were robust under sensitivity analysis. CONCLUSIONS: Under the model assumptions, use of LPV/r in the first ARV regimen, as compared to NFV, leads to cost savings over the first 5 years of therapy, and appears to be cost effective over the patients lifetime.

**COST-CONSEQUENCE COMPARISON OF LOPINAVIR/RITONAVIR (LPV/r) VS. NELFINAVIR (NFV) THERAPY IN TREATING ANTIRETROVIRAL NAÏVE HIV PATIENTS USING CLINICAL TRIAL DATA**

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