angiography (DSA) when used to diagnose peripheral arterial occlusive disease (PAOD) from a German Hospital’s perspective. METHODS: In this study we considered the direct cost attributable to the radiological department in a hospital, including proportionate investigation costs such as personnel and machine usage. The costs for contrast agents and consumer goods were considered in a second step as they vary strongly from hospital to hospital. A total of eleven examinations, each of MRA and DSA type, were documented and analyzed. RESULTS: The investigation costs for a DSA examination excluding consumer goods was found to be €182.38 and about 20% ($34.25) lower than that of a DSA-examination ($376.63), owing to the shorter occupation time of the operating room with MRA (average: 32 minutes) than with DSA (average: 58 minutes) and resulting in a lower proportional investigation costs for machine, room, and personnel per examination assuming routine operating hours of 12 hours per day at seven days a week. When the last prices for consumer goods were also regarded, there was still an advantage for MRA of 11.22 (~7%) per examination.

CONCLUSIONS: For patients with suspected PAOD angiography with contrast-enhanced MRA was found to be less costly than DSA. Our results align with cost-effectiveness analyses conducted in the UK and the USA that included in addition the outcomes of diagnosis-based therapeutic decisions. Increased use of contrast-enhanced MRA for diagnostic purposes and optimization of cost drivers might promote cost reductions in radiological departments in German hospitals.

**PCV123**

**COST OF ARTERIAL HYPERTENSION ACCORDING TO LEVELS OF MORBIDITY IN PRIMARY CARE SETTING**

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**OBJECTIVES:** To determine the health care cost and the labour incapacity of hypertensive patients in the primary care setting (PC). **METHODS:** Retrospective-multicentric design. Patients ≥ 40 year from seven teams of PC (year 2008) were included. Main measures: age, sex, cardiovascular co-morbidity, Charlson index and general morbidity levels (Adjusted Clinical Groups; low, moderate and high). It was established a model of direct costs (differentiating fixed and variable [drugs, tests and referrals]) and indirect. Logistic regression analysis and ANCOVA was used for the model correction. Statistical significance: P < 0.05.

**RESULTS:** The prevalence of hypertension was 28.4% (95% confidence interval [CI]: 27.4–29.4%), mean age 67.5 (11.7) years and 56.7% of female. 73.2% of patients had a low co-morbidity (95% CI: 71.3–75.1%), the average/unit of the total cost was €1131.2 (range, low co-morbidity: €633.1, moderately: €1297.2 and high: €2307.8, P < 0.001). Health care cost represented 98.2% of the whole and medication 69.4%. Morbidity with high cardiovascular events (OR = 3.5), smoking (OR = 1.4) and fixed cost (OR = 0.7) was associated. The correlation analysis with total cost and the episode numbers was 51.4% and 50.6% respectively, P < 0.001.

**CONCLUSIONS:** Patients with AHF have a high health care cost, mainly in pharmacy. The total costs increase with age and level of general morbidity. The AHF should be considered in conjunction with other cardiovascular risk factors. The cost in work labour incapacity is low.

**PCV124**

**COST OF CORONARY ARTERY BYPASS GRAFT (CABG) IN ACUTE HEART FAILURE PATIENTS IN THE CZECH REPUBLIC**

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**OBJECTIVES:** To assess in-hospital costs of CABG in patients hospitalized with acute heart failure (AHF) from a German Hospital’s perspective. **METHODS:** In total in-hospital cost of AHF. **RESULTS:** The prevalence of hypertension was 28.4% (95% confidence interval [CI]: 27.4–29.4%), mean age 67.5 (11.7) years and 56.7% of female. 73.2% of patients had a low co-morbidity (95% CI: 71.3–75.1%), the average/unit of the total cost was €1131.2 (range, low co-morbidity: €633.1, moderately: €1297.2 and high: €2307.8, P < 0.001). Health care cost represented 98.2% of the whole and medication 69.4%. Morbidity with high cardiovascular events (OR = 3.5), smoking (OR = 1.4) and fixed cost (OR = 0.7) was associated. The correlation analysis with total cost and the episode numbers was 51.4% and 50.6% respectively, P < 0.001.

**CONCLUSIONS:** Patients with AHF have a high health care cost, mainly in pharmacy. The total costs increase with age and level of general morbidity. The AHF should be considered in conjunction with other cardiovascular risk factors. The cost in work labour incapacity is low.

**PCV125**

**EVALUATION OF THE ASSOCIATION BETWEEN SERUM SODIUM AND LENGTH OF STAY (LOS) IN PATIENTS HOSPITALIZED FOR HEART FAILURE**

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**OBJECTIVES:** To determine the health care cost and the labour incapacity of hypertensive patients in the primary care setting (PC). **METHODS:** Retrospective-multicentric design. Patients ≥ 40 year from seven teams of PC (year 2008) were included. Main measures: age, sex, cardiovascular co-morbidity, Charlson index and general morbidity levels (Adjusted Clinical Groups; low, moderate and high). It was established a model of direct costs (differentiating fixed and variable [drugs, tests and referrals]) and indirect. Logistic regression analysis and ANCOVA was used for the model correction. Statistical significance: P < 0.05.

**RESULTS:** The prevalence of hypertension was 28.4% (95% confidence interval [CI]: 27.4–29.4%), mean age 67.5 (11.7) years and 56.7% of female. 73.2% of patients had a low co-morbidity (95% CI: 71.3–75.1%), the average/unit of the total cost was €1131.2 (range, low co-morbidity: €633.1, moderately: €1297.2 and high: €2307.8, P < 0.001). Health care cost represented 98.2% of the whole and medication 69.4%. Morbidity with high cardiovascular events (OR = 3.5), smoking (OR = 1.4) and fixed cost (OR = 0.7) was associated. The correlation analysis with total cost and the episode numbers was 51.4% and 50.6% respectively, P < 0.001.

**CONCLUSIONS:** Patients with AHF have a high health care cost, mainly in pharmacy. The total costs increase with age and level of general morbidity. The AHF should be considered in conjunction with other cardiovascular risk factors. The cost in work labour incapacity is low.

**PCV126**

**REDUCTION IN REHOSPITALIZATIONS AND ASSOCIATED COSTS WITHIN 30 DAYS AFTER DISCHARGE FROM HOSPITALIZATION FOR ACUTE CORONARY SYNDROME: A Prospective, Randomized, Double-blind, Placebo-controlled, Parallel-arm, Multicenter, Ongoing, Long-term Prasugrel vs. Clopidogrel: RESULTS FROM THE TRITON-TIMI 38 Trial for Patients with No History of Stroke or TIA**

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**OBJECTIVES:** Readmission within 30 days of discharge following an acute myocardial infarction (AMI) has been adopted as a quality indicator for US hospitals. When specific therapeutic interventions lead to reductions in hospitalization rates, the mechanism of this reduction is unknown. **METHODS:** We compared rates of readmission within 30 days, and associated hospitalization costs in patients who were originally admitted for acute coronary syndromes (ACS) with planned PCI, and treated with prasugrel vs. clopidogrel in the TRITON-TIMI 38 Trial. Patients with a history of stroke/TIA were excluded. Data for rehospitalizations were collected for patients from 8 pre-specified countries (U.S., Australia, Canada, Germany, Italy, Spain, UK, France; n = 3233 prasugrel, n = 3215 clopidogrel). Diagnosis Related Groups (DRGs) were used to classify type of hospitalization, to which average 2005 Medicare reimbursement rates were applied. Rehospitalization rates were compared between groups using Poisson regression. **RESULTS:** There was a reduction in the 30-day rate of rehospitalization for revascularization (PCI or CABG) with prasugrel vs. clopidogrel (4.33 vs. 5.69 per 100 patients, p = 0.015) as well as for PCI (3.80 vs. 4.95 per 100 patients, p = 0.03). The reduction in PCI rehospitalizations was primarily among patients with both PCI and AMI (0.31 vs. 1.06, p = 0.0006). For patients with an index ST-elevation MI, there was a significant reduction in PCI rehospitalizations in the setting of an MI (0.28 vs. 1.46, p = 0.0006). For patients with an index non-ST-elevation MI, the difference in costs between PCI-related rehospitalizations was $214 ($387; 49). **CONCLUSIONS:** For ACS patients with no history of stroke/TIA and planned PCI, treatment with prasugrel vs. clopidogrel is associated with a lower rate of rehospitalization for revascularization–primarily PCI in the setting of MI, and concomitant cost savings. These results may be useful in establishing patient management strategies in the current quality and reimbursement environment.