Vascular interventions account for 61% of hospitalization costs, overall. CONCLUSIONS: Rates and costs of vascular events/interventions are high in patients with PAD, and increase with identifiable risk factors. Risk factor modification and prevention efforts are needed to lessen the burden of atherothrombotic disease for PAD patients, and society.

INFLUENCE THE CO-MORBIDITY AND DIRECT COSTS OF STROKE TO POPULATION SETTING AND IN CLINICAL PRACTICE

Sicras-Mainar A1, Navarro-Artieda R2, Sánchez Maestre C3, Fernández de Bobadilla J4
1Badalona Servicios Asistenciales, Barcelona, Spain, 2Hospital Germans Trias y Pujol, Barcelona, Spain, 3Pfizer Spain, Madrid, Spain, 4Hospital de la Paz, Madrid, Spain

OBJECTIVES: To determine the co-morbidity and direct costs of stroke among Spanish population in daily medical practice.

METHODS: A retrospective study was performed based on data from patients attended for stroke, aged >30 years, from five Spanish primary care centres (PCC) and two hospitals in 2006. Main analysed variables were: age, sex, general or specific (cardiovascular and others) events/co-morbidities, use of drugs, clinical parameters (according to NCEP-ATPIII) and direct costs (pharmacy, derivations, visits, emergencies, procurement, and hospitalisation). An ANCOVA analysis and logistic regression were used to fit the model. RESULTS: Of 57,026 patients included in the analysis, 4.5% (n = 2,585, CI95%: 4.3–4.7%) suffered stroke. The incidence of stroke was 220 new cases/100,000 populations. Main differences between patients suffering stroke and control group were: age (72.5 vs. 53.5), men (58.2% vs. 44.6%), events/year (7.9 vs. 4.8), visits/year (15.8 vs. 8.1), poli-pharmacy (91.5% vs. 53.6%), use of statins (85.0% vs. 32.2%), antihypertensives and/or anticoagulants (78.9% vs. 28.0%), p < 0.001 for all differences. Stroke had an independent relation with age (odds ratio, [OR] = 1.4), male gender (OR = 2.3), diabetes (OR = 1.6), hypertension (OR = 1.5), smoking (OR = 1.5), alcohol abuse (OR = 1.4), depression (OR = 1.4), dyslipidemia (OR = 1.3) and dementia (OR = 1.2). Some of the results were: systolic pressure (134.1 vs. 127.6 mmHg), body mass index (28.9 vs. 27.9 kg/m2) and LDL-cholesterol (116.4 vs. 126.2 mg/dl), in presence/absence of stroke, p < 0.001. After the correction of the logistic model results did not change: €1774.33 (IC: 1720.10–1828.55) vs. €1021.98 (IC: 1010.92–1033.03), p < 0.001. All components of costs were higher in the stroke group. CONCLUSIONS: Prevalence and incidence are similar to that published in the literature. Patients that demanded assistance for stroke had a higher number of co-morbidities and a higher total cost/patient/year. Therapeutic objectives could be improved, mainly in primary prevention of cardiovascular risk factors.

THE BURDEN OF ACUTE CORONARY SYNDROMES IN AUSTRALIA

Liew D1, Price N2
1The University of Melbourne, Melbourne, Australia, 2Sanofi-Aventis Australia Pty Ltd, Sydney, Australia

OBJECTIVES: Clopidogrel (in addition to aspirin) for the treatment of all patients with acute coronary syndromes (ACS) was recently approved for additional reimbursement under the Australian Pharmaceutical Benefits Scheme. We sought to estimate the implications of this approval for the Australian health care system. METHODS: A Markov model to determine cost-effectiveness was constructed by extrapolation of data from the Australian Acute Coronary Syndromes Prospective Audit (ACACIA) registry (n = 2553) in the first model cycle, and the Reduction in Atherothrombosis for Continued Health (REACH) registry (n = 2567) in subsequent model cycles. Efficacy data were drawn from the Clopidogrel in Unstable Angina to Prevent Recurrent Events (CURE) trial. Drug, cardiovascular disease and hospitalisation costs were sourced from the literature and health care reimbursement fees. These were updated as required 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. Data regarding the prevalence of ACS was estimated from published national Australian epidemiological and demographic data. As clopidogrel is already reimbursed for patients who have taken aspirin prior to their event, or who cannot take aspirin due to allergy or intolerance, literature was reviewed to estimate this population. RESULTS: The estimated number of newly eligible patients ranged annually from 48,100 to 62,700 over five years. The expanded treatment coverage was estimated to prevent an additional 12,400 major cardiovascular events (comprising myocardial infarctions, strokes and deaths) in the first five years, leading to a saving of A$175 million in health care costs arising from avoided hospitalisation, procedures and medical services. This has major resource implications for the Australian health system in terms of staffing, bed availability and emergency admissions. CONCLUSIONS: The imminent implementation of unrestricted access to clopidogrel plus aspirin for all ACS patients is likely to lead to significant health and cost savings for Australia.