ventionist cardiology verified the cost of the management of bleeding complications. RESULTS: The management cost of 100 patients subjected to PCI and treated with heparin plus abciximab is €89,023.67, and €57,703.76 if treated with bivalirudin, which results in an incremental cost of €313.2 per patient. In the group of patients subjected to PCI, with the bivalirudin option, and without modifying the hospital budget, 54 out of 100 patients more could be treated with a similar level of protection and a smaller bleeding risk. CONCLUSIONS: Bivalirudina should be considered as the anticoagulant first option in those patients undergoing PCI and that are currently receiving heparin plus glycoprotein IIb/IIIa inhibition.

PCV39

PHARMACOLOGICAL TREATMENT OF HYPERTENSION IN PATIENTS WITH TYPE II DIABETES A COST-MINIMIZATION ANALYSIS
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OBJECTIVE: to study direct medical costs for treatment of mild to moderate hypertension in patients with type II diabetes in the perspective of the Italian National Health care System (NHS).
METHODS: this was a randomized parallel group clinical study; after a 2 weeks run-in period, eligible patients DBPs < 140 mmHg were randomized to treatment with delapril (D) 30 ± 110; SBP mg/die, ramipril 2.5 mg/die (R) or valsartan (V) 80 mg/die. After 6 weeks of active treatment, untreated patients were switched to combination therapies: D + manidipine 10 mg (D + M); R + hydrochlorothiazide 12.5 mg (R + HCTZ); V + hydrochlorothiazide 12.5 mg (V + HCTZ), whilst patients with satisfactory BP levels were kept on monotherapy. The economic analysis was run in the perspective of the Italian NHS; only direct medical costs were considered, including study drugs, unscheduled medical visits and tests, hypoglycaemic drugs and drugs used to treat adverse events. Year 2006 market prices and NHS tariffs were applied; for D + M we considered a target price of €23.24 for 28 tablets pack (not marketed yet in Italy). RESULTS: 425 patients were included (ITT), of which 139 were treated with D/D + M, 145 with R/R + HCTZ and 141 with V/V + HCTZ. No statistically significant differences were found among the 3 study groups, on the primary efficacy variable of DBP, on the number of patients requiring combination therapy and on secondary efficacy parameters. Therefore the economic analysis was a cost-minimization analysis with costs normalised at 1 year to the no rehabilitation group.

A COST CONSEQUENCE ANALYSIS OF THE IMPACT OF JBS 2 ON PATIENTS ELIGIBLE FOR STATIN TREATMENT IN SCOTLAND
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OBJECTIVES: The Joint British Societies (JBS) 2005 guideline on prevention of cardiovascular disease (CVD) advocates prevention in people with established CVD, with diabetes and with CVD risk ≥20% over 10 years. This study was designed to establish the number of patients eligible for statin treatment in Scotland under these new guidelines, compared to those previously eligible under the National Service Framework (NSF) for CHD 2000, and estimate the budget impact of treating these additional patients to the JBS 2 optimal total cholesterol (TC) target of <4.0 mmol/L.
METHODS: Data from the Scottish Health Survey 2003 (mean baseline TC, incidence of CVD and diabetes) were combined with predicted coronary heart disease (CHD) risk estimates and population statistics in an Excel-based model to estimate number of eligible patients. Efficacy data from the STELLAR (Statin Therapies for Elevated Lipid Levels compared Across doses to Rosuvastatin) trial and pack costs from standard sources were used to determine percentage of patients reaching the specified TC target and annual treatment costs for alternative strategies comprising simvastatin 40 mg followed by either atorvastatin (20 mg, 40 mg and 80 mg) or rosvastatin (10 mg, 20 mg and 40 mg). RESULTS: The results using JBS 2, showed 21.3% of the adult population in Scotland is eligible for statin treatment: a total of 881,402 people. Using the NSF, only 12.4% or 513,600 people were eligible, this is an increase of 367,802 (8.9%). The cost of treating these additional patients with the