care of severe sepsis. METHODS: Observational prospective before and after study in 59 medical-surgical intensive care units located throughout Spain. A total of 854 patients were enrolled in the pre-educational program cohort (usual or standard care of severe sepsis, November-December 2003) and 1463 patients during the post-educational program. Protocol-based care of severe sepsis, March-June 2004. The educational program aimed to increase the adherence to the SSC protocol. The SSC protocol included pharmacological (antibiotics, fluids, steroids and drotrecogin alfa (activated)) and medical (early-goal directed therapy, tight glycose control and lung protective strategy) interventions. Clinical (hospital mortality) and economical (health care resource and treatment costs) outcomes were recorded. Health care system perspective was used for costs. Incremental cost-effectiveness ratios (ICERs) and incremental cost-utility ratios (ICURs) were used as primary outcomes. ICERs and ICURs were estimated by using multivariable regression models and its variability was addressed by using bootstrapping. RESULTS: Patients in the SSC protocol care cohort had a lower risk of hospital mortality (44.0% vs. 39.7%, P = 0.04). However, the SSC protocol care resulted in a mean increase in cost of €1800 per patient, largely driven by increased length of stay. Mean life years gained (LYG) and quality-adjusted life years (QALYs) were higher in the SSC protocol care cohort: 0.7 years and 0.5 QALYs, respectively. The adjusted ICER of the SSC protocol was €2556.9 per LYG and the adjusted ICUR was €5759.6 per QALY. Ninety percent of the bootstrap replications were below the threshold of €30,000 per LYG. CONCLUSIONS: The SSC protocol seems to be a cost-effectiveness option for treating severe sepsis in Spain.

A COMPARISON OF THE COST-EFFECTIVENESS OF THE 13-VALENT (PCV13) AND 10-VALENT PNEUMOCOCCAL CONJUGATE VACCINES IN THE UK

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OBJECTIVES: To assess the cost-effectiveness of atazanavir/r vs. lopinavir/r in treatment-naive HIV patients in Spain. METHODS: A life-time Markov cohort model was created with the following health states 1st line, 2nd line and salvage therapy. The model predicted the number of patients who could switch treatment due to lack of efficacy or non-compliance. Those discontinuing 1st line treatment due lack of efficacy switched to darunavir/r. Those that discontinued 1st line due to adverse events or non-compliance switched to efavirenz/entecavir/tenofovir. Everyone discontinuing 2nd line was given a salvage therapy. Patients were at risk of developing a cardiovascular event or to die in each state. Drug specific safety and efficacy inputs were taken from the 48 week CASTLE trial, risk of cardiovascular events were estimated with Framingham equation and risk of death was from Spanish life-tables. RESULTS: Our analysis found that atazanavir/r has a 23.5% and a 76.5% probability to be in the NE and SE quadrant of cost-effectiveness plane. Univariate sensitivity analysis showed that results were most sensitive to changes in probabilities of switching treatment. In the scenario analysis quadrants of cost-effectiveness plane. Univariate sensitivity analysis showed that results were most sensitive to changes in probabilities of switching treatment. In the scenario analysis driven by increased length of stay. Mean life years gained (LYG) and quality-adjusted life years (QALYs) were higher in the SSC protocol care cohort: 0.7 years and 0.5 QALYs, respectively. The adjusted ICER of the SSC protocol was €2556.9 per LYG and the adjusted ICUR was €5759.6 per QALY. Ninety percent of the bootstrap replications were below the threshold of €30,000 per LYG. CONCLUSIONS: The SSC protocol seems to be a cost-effectiveness option for treating severe sepsis in Spain.

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