RESULTS: Non-compliance is a significant problem in managing hypercholesterolaemia. Discontinuation rates for statins in normal practice average 30% after six months. This results in a significant loss of therapeutic response. In the EXCEL study (lovastatin), a 41.3% reduction in LDL cholesterol was observed in those patients who reported taking all their tablets. This compared with a 26.6% reduction in those taking 80% of their tablets. In a primary-care setting, the discontinuation rate for pravastatin was 24% after two years. The reduction in LDL cholesterol was 6% compared to 26% in those continuing treatment. This results in a change in cost-effectiveness from £376 to £1754 per % LDL reduction per year.

CONCLUSIONS: Noncompliance is an important factor when assessing a drug’s effectiveness in clinical practice. Tables comparing the cost-effectiveness of statins are often found in the medical literature, but rarely do they account for noncompliance. The present study illustrates the need to account for the impact of noncompliance in pharmacoeconomic evaluations.

ENOXAPARIN — A PHARMACOECONOMIC REVIEW OF ITS USE IN ACUTE CORONARY SYNDROMES
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OBJECTIVE: The development of low-molecular-weight heparins (LMWHs) as an antithrombin therapy for the management of acute coronary syndromes was prompted by the shortcomings of unfractionated heparin (UFH), the standard therapy. LMWHs, and especially the most widely used enoxaparin, offer the advantages of a stable and predictable anticoagulant response to a given dose, eliminating the need for haematologic monitoring, and much simpler administration via the subcutaneous route. However, enoxaparin should achieve improved clinical effectiveness and demonstrate economic attractiveness. The present review is an appraisal of the relative costs and benefits of enoxaparin versus UFH in acute cardiology.

METHODS: A growing number of papers have been addressing these questions during the last five years. Most of them are based on two worldwide multi-center, double-blind, randomized controlled trials, TIMI 11B and ESSENCE, involving patients with unstable angina/ non-Q wave myocardial infarction. Efficiency was evaluated prospectively over the first 30 days of follow-up and retrospectively after one year of follow up, using cost-effectiveness approach. Only direct costs were measured.

RESULTS: Enoxaparin was shown to be a dominant strategy. It clearly improved efficacy and tolerability versus UFH, providing an absolute risk reduction of death, myocardial infarction and recurrent angina of 3.7% to 3.5% at more or less short term. Average cost per patient was significantly lower due to reduced frequency of diagnostic catheterization, revascularization procedures, angiography, coronary angioplasty and shorter length of hospital stay over the first 30 days. Cost reduction arose, on the long term, from less rehospitalizations and revascularizations. Moreover, those reductions were probably underestimated as indirect costs were not considered.
CONCLUSION: Superior clinical efficacy combined with substantial cost savings for at least one year of follow-up conferred to enoxaparin a place of choice in acute cardiology therapy.

**PCV8**

**COST-EFFECTIVENESS OF CLOPIDOGREL COMPARED WITH TICLOPIDINE IN THROMBOSIS PREVENTION: DECISION ANALYSIS TAKING INTO ACCOUNT SIDE-EFFECTS**

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OBJECTIVE: To determine the cost-effectiveness of thrombosis prevention with Clopidogrel versus Ticlopidine in Russia, taking into account side effect such as agranulocytosis (neutropenia) using a decision analysis.

METHODS: Pharmacoeconomic comparison using a decision tree model was based on the assumption that Ticlopidine (250 mg daily) causes short-duration neutropenia in 0.8% of patients compared to 0.04% of patients on Clopidogrel (37.5 mg daily) one month after treatment starts. The probabilities of neutropenia were derived from multi-center clinical trials of antithrombotic therapy safety. Calculated costs included cost of study drugs and direct medical costs for neutropenia treatment. A neutropenia treatment scheme was analyzed by reviewing medical charts of patients with short-duration neutropenia at the Federal Hematological Center. Effectiveness was measured by percentage reduction in spontaneous platelet aggregation (SPA) in a comparative clinical study including 70 patients with thrombophilia. Cost effectiveness ratio (CER) was defined for both drugs and incremental cost-effectiveness ratio (ICER) was determined.

RESULTS: The mean costs of medication treatment were 1221 rubles (42.1$) for Clopidogrel and 795 rubles (27.4$) for Ticlopidine. The median direct medical cost for treatment of neutropenia was 28,126 rubles (969.9$) per patient. Expected costs for antiplatelet therapy, taking into account the probability of neutropenia, was 1020 rubles (35.2$) for Ticlopidine and 1232 rubles (42.5$) for Clopidogrel. The CER for Ticlopidine was 1020 rubles (35.2$) for Ticlopidine and 1232 rubles (42.5$) for Clopidogrel. The CER for Clopidogrel was 1020 rubles (35.2$) for Ticlopidine and 1232 rubles (42.5$) for Clopidogrel. The ICER for Clopidogrel vs. Ticlopidine was 14.5 rub (0.5$) per 1% SPA reduction. The ICER for Clopidogrel vs. Ticlopidine was 14.5 rub (0.5$) per 1% SPA reduction. The ICER for Ticlopidine vs. Ticlopidine was 14.5 rub (0.5$) per 1% SPA reduction. The ICER for Ticlopidine vs. Ticlopidine was 14.5 rub (0.5$) per 1% SPA reduction.

CONCLUSION: Clopidogrel is more effective and safer than Ticlopidine. Though costs for Clopidogrel including treatment of side effects (neutropenia) were higher than for Ticlopidine, ICER shows that additional effects can be achieved at a reasonable cost.

**PCV9**

**COST-EFFECTIVENESS OF EPTIFIBATIDE IN THE UK BASED ON PURSUIT TRIAL**

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OBJECTIVE: To conduct an economic analysis of the PURSUIT trial in the UK for patients with unstable angina or non-Q-wave myocardial infarction (MI) admitted to hospital and randomized to eptifibatide (GPIIb/IIIa) or placebo in addition to usual therapy.

METHODS: Health-care resource consumption was collected prospectively for all patients in the PURSUIT trial. Unit costs were developed for the UK and applied to the resources consumed in the trial to estimate the cost per patient treated during index hospital stay and at six months follow-up. Analyses were conducted using resource consumption from the UK sub population, Western European (WE) sub population, and the total PURSUIT trial population. Long term outcome measures were based on life expectancy estimated from six-month PURSUIT data of the WE sub population and the North American (NA) + WE sub populations.

RESULTS: Initial hospital and six-month costs for eptifibatide patients including drug cost were slightly higher than the placebo group using the WE and overall trial population resources. UK-specific resource consumption was lower in the eptifibatide group. The difference in 30-day rate of death and MI was 1% (NS) for WE and 1.5% (p = 0.04) for the overall trial. At six months, MI rates were further decreased for eptifibatide but no difference existed in mortality between the groups. The CE ratios (discounted at 3%) using WE or overall resources are £8,436 and £12,591 respectively using WE survival or £3,418 and £5,036 using WE + NA survival. Using UK resources, eptifibatide is cost saving in either survival scenario.

CONCLUSION: The cost-effectiveness ratios for eptifibatide in the UK all fall within an acceptable range for adopting new technology. The impact of resource consumption data on the cost-effectiveness ratio underscores the importance of the source of treatment-pattern data and the need for prospective or retrospective data collection to reflect country-management styles.

**PCV10**

**A PHARMACOECONOMIC ANALYSIS OF PATIENT OUTCOMES IN THE CORONARY ANGIOPLASTY AMLODIPINE RESTENOSIS STUDY (CAPARES) IN NORWAY AND CANADA**

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OBJECTIVE: The objective of this analysis was to evaluate the health-economic benefits of using amlodipine in patients undergoing angioplasty procedures from the perspectives of the Canadian Ontario Ministry of Health and the Norwegian National Health Service.