goal was highest when increasing the statin dose (0.406), followed by changing to a different statin (0.387), adding an additional therapy to the statin (0.320), not changing therapy (0.306), and changing the statin to an alternative therapy (0.111). The decision with the lowest average cost-effective ratio was increasing the statin dose ($331.75). Incremental analysis showed the cost of getting one more patient to goal was the lowest for changing to a different statin ($126.85), followed by increasing the statin dose ($173.16), and changing to an alternative therapy ($868.38). Sensitivity analysis found robust results for the probabilities of reaching goal. Cost data was sensitive between the decisions of increasing statin dose and changing statins. CONCLUSION: The most cost-effective decisions in this study were to increase the statin dose or change to a different statin.

PCV30
COST-EFFECTIVENESS OF STATINS IN CARDIOVASCULAR RISK MANAGEMENT: SYSTEMATIC REVIEW
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OBJECTIVES: Statin therapy reduces the rate of cardiovascular disease, but high costs in combination with a large population eligible for treatment ask for priority setting. Although trials agree on the size of the benefit, economical analyses of statins report contradictory results. METHODS: We reviewed cost effectiveness analyses comparing statins with no treatment and sought to synthesize cost effectiveness ratios for categories of risk of coronary heart disease and age. Data Sources: Medline, the British National Health Service Economic Evaluation database and authors’ reference lists. We searched for studies comparing statins to no treatment for the prevention of cardiovascular disease in adult male populations. Reviews and meta-analyses were excluded. Studies needed to present cost per Years of Life Gained/Saved (YLS, YLG) as outcome. Studies comparing statins with other statins, or other medications were excluded. RESULTS: Twenty-four studies were included, yielding 216 cost effectiveness ratios. As expected, cost effectiveness ratios increase with decreasing absolute risk. However after stratification by absolute risk, heterogeneity of CER is large with outcomes varying from savings to US$59,000 per year saved in the highest risk category and from US$6500 to 490,000 in the lowest risk category Disagreement increased at lower levels of risk. Absolute risk was the only significant predictor of cost effectiveness ratios. Various significant interactions with absolute risk were found. CONCLUSION: Statin therapy is cheap for high levels of risk, but discrepancies exist at lower levels of risk. Although the cost-effectiveness of statins depends mainly on absolute risk, factors like age, funding source and methodological variables might be behind the ample remaining heterogeneity of the CER after adjusting for absolute risk. Economic analyses need to increase their transparency to reduce their vulnerability to bias and increase their reproducibility.

PCV31
ECONOMIC ANALYSIS OF AMIODARONE, ATRIAL SEPTAL PACING VERSUS STANDARD OF CARE TO PREVENT ATRIAL FIBRILLATION AFTER OPEN-HEART SURGERY
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OBJECTIVES: To compare the cost-effectiveness of amiodarone, atrial septal pacing, amiodarone plus atrial septal pacing, in addition to standard therapy with beta-blockers, to standard therapy alone to prevent postoperative atrial fibrillation in patients undergoing open-heart surgery. METHODS: A piggyback cost-effectiveness analysis of a randomized, placebo-controlled, 2 x 2 factorial trial was conducted from a hospital perspective. Charges were converted to costs using cost-to-charge ratios. For the cost-effectiveness analysis, a joint distribution of costs and effectiveness was performed using the nonparametric bootstrap method. RESULTS: The incidence of postoperative atrial fibrillation was 38%, 28%, 40%, and 16% with standard care, amiodarone, atrial septal pacing, and amiodarone plus atrial pacing, respectively (standard care vs. amiodarone + pacing, p = 0.047; pacing vs. amiodarone + pacing, p = 0.04). Total costs (mean ± SD) were $27,026 ± 30,226 in the standard of care, $22,725 ± 17,661 in the amiodarone, $33,868 ± 60,309 in the atrial septal pacing and $18,697 ± 8,174 in the amiodarone plus atrial septal pacing groups (p = 0.27). In the joint distribution cost-effectiveness analysis, compared to standard of care, the probability of lower cost but higher effect (superiority) was 67% for amiodarone, 15% for atrial septal pacing, and 97% for amiodarone plus atrial septal pacing. In multivariate analysis, preoperative beta-blockers and amiodarone were negatively associated with hospital costs (p < 0.05). CONCLUSIONS: Data suggest that amiodarone and amiodarone plus atrial septal pacing are cost-effective compared to standard therapy alone. Additional comparative studies between these strategies are warranted to confirm these findings.

PCV32
USE OF ANTILIPEMIC DRUGS IN NATIONAL HEALTH CARE GROUP (NHG), SINGAPORE
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OBJECTIVES: To assess the use and cost of antilipemic drugs in NHG institutions. METHODS: Dispensing data for antilipemic drugs for various NHG institutions from Jan–Sept 2003 was extracted and analysed using WHO ATC/DDD methodology (version 2004). Setting: Primary care: NHG Polyclinics (NHGP), Secondary care: Alexandra Hospital (AH) and Tan Tock Seng Hospital (TTSH)—the latter has large general medicine and geriatric departments. Tertiary care: National University Hospital (NUH)—which has a large cardiac department and an active lipid clinic. RESULTS: Statins accounted for 90% (88–92%) whereas fibrates accounted for 10% (8–12%) of total DDDS. Lovastatin and simvastatin dominated the antilipemic drugs use (83% of total DDDS). Although atorvastatin and pravastatin’s usage was less than 7% of total DDDS, they accounted for almost 50% of the total cost for antilipemic drugs. The total usage and cost of antilipemic drugs were highest in NHGP. Atorvastatin and pravastatin were used more commonly in NUH and TTSH (22% & 17% respectively) and resulted in higher (2–3 times) average daily cost as compared to AH & NHGP (2% for both institutions). The analysis also revealed that NHU & NHGP have a higher average daily cost of bile acid sequestrants and nicotinic acid derivatives respectively due to the use of more expensive agents in these groups of drugs. CONCLUSIONS: Generally, the utilisation profile of the broad classes of antilipemic drugs was similar across the four institutions. Statins were the leading antilipemic drugs followed by fibrates. Some institutions used more expensive antilipemic drugs as compared to the others. This has significant cost implication to patients and institutions. A closer analysis of patterns of antilipemic drug