as the number of symptomatic arterial disease locations increases. A cost-utility analysis was undertaken comparing two years of clopidogrel treatment with aspirin treatment for patients with a previous history of MI, who then sustain an IS or a peripheral arterial disease (PAD) event. These patients are referred to as ‘high-risk’. METHODS: A model was constructed to simulate hypothetical ‘high-risk’ patients. The time horizon was that of patient lifetime with only direct medical costs considered. Health states included were vascular death, non-fatal IS events and non-fatal MI events. The risk of future events in the ‘high-risk’ group compared with patients who had sustained a single event (MI, IS or PAD) was calculated from the CAPRIE trial and showed an 81% increase. This ratio was applied to previously published risks of vascular death, non-fatal IS and non-fatal MI for UK patients with a single event to calculate the event rates for ‘high-risk’ patients. The relative risks (and 95% confidence intervals) of clopidogrel compared with aspirin in ‘high-risk’ patients in the CAPRIE trial were 0.87 (0.63–1.19), 0.83 (0.60–1.15) and 0.53 (0.32–0.86) for vascular death, non-fatal IS and non-fatal MI events respectively. Costs and utilities associated with events were taken from literature reviews and were discounted at 3.5% per annum. Probabilistic sensitivity analyses were undertaken. RESULTS: The mean cost per QALY for clopidogrel compared with aspirin was $5443 (95% confidence interval $2332 to dominated). The probability of the cost per QALY being below $20,000, a significant threshold for cost-effectiveness in the UK, was 79%. CONCLUSION: The model suggests that, in patients with a previous MI event and a subsequent IS or PAD event, clopidogrel can be considered cost-effective compared with aspirin in terms of current UK thresholds.

PCV32
COST-EFFECTIVENESS OF CLINICAL PHARMACY SERVICES ON HYPERLIPIDAEMIC MANAGEMENT IN A PUBLIC HOSPITAL OF HONG KONG
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OBJECTIVE: This study was aimed to evaluate the economic benefits of clinical pharmacy service in hyperlipidaemic management in accordance to the ATP III guidelines. METHODS: A clinical pharmacy service was developed at the lipid clinic of Prince of Wales Hospital (PWH) between October 2005 and October 2007. In the intervention group, patients attended educational visits conducted by a clinical pharmacist. Medication compliance and the proper use of drugs were assessed. Monthly telephone follow-ups were made to check on the progress of patients. The time spent by the pharmacist was recorded. In the control group, patients received usual medical care with no pharmacist intervention. RESULTS: A total of 300 patients were recruited (150 in the intervention group and 150 in the control group). Intervention group achieved 23.6%, 15.3%, and 22.3% mean reduction in LDL-C, total cholesterol and triglyceride levels, respectively, compared with 3.7%, 5.2%, and 2.7% in the control group. A sustained reduction in total cholesterol of 1% is associated with a 2–3% reduction in CHD risk. Pharmacist conducted mean of 3.34 + 0.7 educational visits and 16.3 + 3.3 telephone follow-up calls. The overall time spent was 3.08 minutes per patient per week. The average monthly salary of a hospital pharmacist was HK$30,000 (HK$7.8 = USD$1). In previously published data, 0.39 patients per year at the PWH lipid clinic experienced acute myocardial infarction (AMI) and required HK$28,800 medical cost annually. Clinical pharmacy service reduced the CHD risk of these patients and prevented the development of an AMI, providing a potential cost saving of HK$28,600 (which was 99% cost reduction) per patient per year at PWH. (Estimated cost of pharmacist to manage 0.39 patients per year is HK$182.18). CONCLUSION: Clinical pharmacy service is potentially a cost-effective way to improve the management of hyperlipidaemia alongside with routine physician care.

PCV33
LONG-TERM REDUCTION OF CARDIOVASCULAR EVENTS AND COST-EFFECTIVENESS OF DIFFERENT STATINS AND DOSES IN MEXICO
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OBJECTIVE: To assess long-term reduction of cardiovascular (CV) events and cost-effectiveness of the use of rosuvastatin (Rsv), atorvastatin (ATV), simvastatin (SIM) and pravastatin (PRA) in Mexican patients over 55 years old. METHODS: Efficacy data from STELLAR clinical trial (total cholesterol -TC-, LDL-C; HDL-C, triglycerides -TG-) was used as input to the model. Based on Framingham risk equations, 4 gender/risk

Abstracts

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COST-EFFECTIVENESS OF DIFFERENT STRATEGIES FOR DIAGNOSIS OF DEEP VEIN THROMBOSIS
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OBJECTIVE: Proper diagnosis of Deep Vein Thrombosis (DVT) at the earliest time is very important so that appropriate therapy can be initiated. Various diagnostic tests have been developed for DVT, but most of them have poor sensitivity and specificity. Due to the above issues, it is very important that diagnosis strategies be developed which are cost-effective. METHODS: Cost-effectiveness was analyzed using a decision model from TreeAge Pro Suite 2007 software. Outcomes considered were costs, adverse events and quality adjusted life years (QALY’s). Probabilities were calculated using Bayes’ revision method that utilized sensitivity and specificity of the diagnostic tests along with the pretest probability of developing the disease. Quality of life and costs data were pooled from literature reviews. QALY’s were calculated using life expectancy tables. Costs in pounds were converted to US dollars and adjusted through use of Consumer Price Index data from Bureau of Labor Statistics. RESULTS: With a cost-effectiveness ratio of $32.4995 per QALY, the following strategy dominated other alternate strategies—Perform venography if D-dimer test is positive. Otherwise, if D-dimer test is negative then no treatment is given. If venography shows abnormal results, treatment is given otherwise for normal results, no treatment is given. Sensitivity analysis showed that this strategy remained cost-effective even when all costs were varied by 25%. The model results were affected by the sensitivity of the diagnostic tests. CONCLUSION: Based on this analysis, it would be cost-effective if symptomatic patients are diagnosed with the strategy after classifying them according to Wells score. Further research needs to be done to see if cost of venography is offset by decrease in hospitalization of those who later develop severe form of DVT. Health care providers should consider patient population distribution among the risk groups defined by Wells score before generalizing the finding.

PCV31
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OBJECTIVE: To assess long-term reduction of cardiovascular (CV) events and cost-effectiveness of the use of rosuvastatin (Rsv), atorvastatin (ATV), simvastatin (SIM) and pravastatin (PRA) in Mexican patients over 55 years old. METHODS: Efficacy data from STELLAR clinical trial (total cholesterol -TC-, LDL-C; HDL-C, triglycerides -TG-) was used as input to the model. Based on Framingham risk equations, 4 gender/risk