an additional cost of €1479. The incremental CE was €5154/LYG (95% confidence interval (CI) €3833/LYG-€9944/LYG). Sensitivity analyses on effectiveness, cost of complications and discounting shows the robustness of the results. A 2nd order Monte Carlo analysis based on the 95% CI obtained in the GISSI study showed that in 99.1% of patients n-3 PUFAs is a cost-effective treatment option if €20,000/LYG is taken as a threshold. **CONCLUSIONS:** Adding n-3 PUFAs to standard treatment in the secondary prevention after MI appears cost-effective in Belgium.

CV10

COST-EFFECTIVENESS OF LOVASTATIN, CHOLESTYRAMINE AND GEMFIBROZIL FOR THE PRIMARY PREVENTION OF CORONARY HEART DISEASE THROUGH CHOLESTEROL REDUCTION IN CATALONIA, SPAIN

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OBJECTIVES: The cost-effectiveness of hypolipemiant treatment with lovastatin (HMG-CoA reductase inhibitor, 20, 40 and 80 mg/day), cholestyramine (bile acid sequestrant, 12 and 24 g/day) gemfibrozil (fibrate, 1,2 g/day) in individuals with hypercholesterolemia >200 mg/day was assessed in this study. **METHODS:** Cost-effectiveness was measured in terms of met cost per life year gained (LYG) comparing costs and benefits in Spain. The net treatment cost was defined as the total cost including medication, control measures and treatment of adverse side effects less savings from coronary heart disease costs. Effectiveness was measured using the Framingham equation, the information about the prevalence of cardiovascular risk factors, and life expectancy according to age and sex in Catalonia. Cost and benefits were discounted using a 5% discount rate. **RESULTS:** The ranking list of efficiency in both men and women and for different pre-treatment cholesterol levels was: lovastatin 20 mg/day, cholestyramine 12 g/day, lovastatin 40 mg/day, gemfibrozil 1.2 g/day, cholestyramine 24 g/day, and lovastatin 80 mg/day. Cost-effectiveness in terms of cost per LGY ranged from $15,487 to 289,116 in men and from $52,403 to 604,809 in women, according to age, sex, and cholesterol concentration. In individuals with a cholesterol concentration of 300 mg/dl cost-effectiveness ranged from $33,850 to 142,910 per LYG in men and from $104,100 to 350,660 per LYG in women. The highest cost-effectiveness was obtained in men aged 40–44 years with 380 mg/dl of cholesterol and in women aged 50–54 years with 380 mg/dl of cholesterol, while the lowest cost-effectiveness was observed in both men and women aged 70–75 years with 200 mg/dl of cholesterol. Incremental cost-effectiveness analysis showed that treating individuals with hypercholesterolemia using lovastatin was more cost-effective than using cholestyramine and gemfibrozil. **CONCLUSION:** This study has shown that lovastatin, an HMG Co-A reductase inhibitor, was the most cost-effective hypolipemiant drug assessed in this study.

CV11

CONTROLRISC STUDY: EVALUATION OF THE MODIFICATION IN CARDIOVASCULAR RISK IN HYPERTENSIVE PATIENTS IN PRIMARY CARE THROUGH PATIENT PERSONALIZED EDUCATION

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OBJECTIVES: To evaluate the effectiveness in the modification of cardiovascular risk (CVR) according to WHO-ISH guidelines of an educative personalized intervention in hypertensive (HT) patients in primary care. **METHODS:** Observational, prospective and controlled study. Two hundred seventy-nine general practitioners (GP) were recruited throughout Spain. HT patients were followed for six months. Investigators were cluster-randomized to Control group (CG) and Intervention group (IG). The CG investigators did usual clinical practice, whereas IG investigators did usual clinical practice plus a personalized educative intervention, which consisted in the ad hoc printing by using a specific software of educative leaflets oriented to the modification of life habits and to control of cardiovascular risk factors for each patient. **RESULTS:** HT patients totaling 4,019 were evaluated. Both groups were comparative at baseline with respect to sociodemographic variables and CVR distribution. The IG showed a statistically significant and clinically relevant improvement in hypertension control (54.1% of controlled hypertension in IG vs. 48.0% in CG; $p < 0.01$). The final CVR distribution was significantly better in the IG than in the CG. The IG patients improved significantly their knowledge of hypertension disease (from 36.8% to 80.6% of good knowledge in IG vs from 32.5% to 70.0% in CG; $p < 0.001$). There were no differences in the evolution of smoking, cholesterol and obesity. The overall satisfaction with medical care was higher in the IG. Of the patients, 90.9% answered "Always" to the question "When you talk to your physician, does he/she answer clearly to your questions?" vs 51.5% of patients in CG ($p < 0.05$). **CONCLUSION:** The proposed procedure for the personalized educative activity with the hypertensive patient has proven to be feasible and useful for hypertension and CVR control in general practitioners. The intervention seems to improve knowledge about hypertension and satisfaction level with medical care.