of key parameters. CONCLUSION: Clopidogrel as an alternative to ASA is a cost-effective strategy in secondary prevention of ischemic events for high-risk atherothrombotic patients.

**COST-EFFECTIVENESS OF A NEW ANTITHROMBOTIC AGENT: A COMPARISON ACROSS COUNTRIES OF THROMBOPROPHYLAXIS WITH FONDAPARINUX FOLLOWING MAJOR ORTHOPAEDIC SURGERY**

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**OBJECTIVES:** Fondaparinux, a new synthetic selective factor XA inhibitor was recently introduced into the market. This may have widespread implications for Health care providers that are expected to vary across countries. We evaluated the cost-effectiveness of fondaparinux relative to enoxaparin up to 5-years in the prevention of venous thromboembolism (VTE) following major orthopaedic surgery and compared the results across European countries. **METHODS:** We developed an economic model and assessed the effect of fondaparinux relative to enoxaparin, both given for 7 days, on patient clinical outcomes and costs in Belgium, Italy, The Netherlands, Spain, UK. The perspective was that of the third party payer. Outcomes are symptomatic deep vein thrombosis, pulmonary embolism, recurrences, post-thrombotic syndrome and death. Data on the incidence of VTE events were derived from four randomised clinical trials comparing enoxaparin with fondaparinux, and from a review of the literature. Resource consequences and costs were estimated locally using national or hospital databases, clinician opinion, literature... and validated by experts. **RESULTS:** In a hypothetical cohort of 1000 patients, weighted to reflect the proportion of patients undergoing hip or knee replacement, or hip fracture surgery in each country, the expected number of VTE events averted with fondaparinux ranged from 17 to 20 and the number of VTE-related deaths averted is 2 to 3. Results were consistent across countries: break-even point in costs was achieved at day 90 or even earlier. The expected savings with fondaparinux at 5 years would range between €26,000 and €38,000. These findings were found to be robust to wide variations in key assumptions in the model. **CONCLUSIONS:** Compared with current practice in Europe, fondaparinux is a cost-effective and dominant strategy in the prophylaxis of venous thromboembolism following major orthopaedic surgery in all countries investigated.

**CLINICAL OUTCOMES AND COSTS OF DRUG ELUTING STENTS IN THE CARDIAC CATHETERIZATION LAB**

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Drug-eluting stents (DES) have been shown to reduce the risk of restenosis post coronary intervention compared with conventional stents (CS). However, the cost of DES is significantly higher than CS. **OBJECTIVE:** To evaluate the utilization of DES along with clinical indications, outcomes and cost impact within the cardiac catheterization lab. **METHODS:** Demographic, clinical and angiographic data were collected retrospectively on all patients who underwent DES implantation between October 15, 2002 and April 15, 2003. Cost data, specifically stent costs, were collected concurrently. **RESULTS:** A cohort of 46 patients was treated with DES, involving 52 vessels and utilizing 62 stents (56 Cypher, 6 Taxus). Indications for coronary intervention were stable angina (67.2%) and ACS/post MI (32.6%). Indications for DES use included clinical reasons such as diabetes mellitus (15.2%), prior bypass surgery (19.6%) and renal insufficiency (8.7%). Angiographic indications included: stenosis length >18 mm (43.4%), vessel diameter <2.5 mm (32.6%), patients with multivessel disease (21.7%) and instent restenosis (8.7%). Short-term clinical complications included death but no strokes or myocardial infarctions. The procedural success was 95.8% (44/46), and the clinical success was 92.5% (43/46). The average number of DES per patient was 1.35. During the same time period, 351 patients were treated with CS, utilizing 522 stents. The average number of stents per patient was 1.48. The total hospital-incurred DES cost was $227,500 for an average stent cost $4945.63 per patient. In the CS group the total cost for stents was $496,050 for an average cost of $1413.25 per patient. The average stent cost per patient was 3.5 times higher in the DES group than with CS. **CONCLUSIONS:** 1) Indications for DES use are consistent with individuals at higher risk for restenosis; 2) the procedural costs for treating these individuals are significantly greater; and 3) full 6 month outcomes and cost data will be available for presentation.

**ADHERENCE/COMPLIANCE**

**LOWER PERSISTENCE WITH ANTIHYPERTENSIVE DRUGS AMONG WOMEN COMPARED TO MEN**

Erkens JA¹, Panneman MJ¹, Klungel OH², van den Boom G³, Herings RMC³

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**OBJECTIVE:** To evaluate adherence with conventional antihypertensive therapy among women compared to men. The primary endpoints of the study were persistence, defined as the proportion of lifetime treated patients who were compliant at least 12 months and 36 months after start of therapy, respectively; drug persistence, defined as the proportion of lifetime treated patients who were compliant for at least 180 days after start of therapy; and full 6 month outcomes and cost impact within the cardiac catheterization lab. **METHODS:** Demographic, clinical and angiographic data were collected retrospectively on all patients who underwent DES implantation between October 15, 2002 and April 15, 2003. Cost data, specifically stent costs, were collected concurrently. **RESULTS:** A cohort of 46 patients was treated with DES, involving 52 vessels and utilizing 62 stents (56 Cypher, 6 Taxus). Indications for coronary intervention were stable angina (67.2%) and ACS/post MI (32.6%). Indications for DES use included clinical reasons such as diabetes mellitus (15.2%), prior bypass surgery (19.6%) and renal insufficiency (8.7%). Angiographic indications included: stenosis length >18 mm (43.4%), vessel diameter <2.5 mm (32.6%), patients with multivessel disease (21.7%) and instent restenosis (8.7%). Short-term clinical complications included death but no strokes or myocardial infarctions. The procedural success was 95.8% (44/46), and the clinical success was 92.5% (43/46). The average number of DES per patient was 1.35. During the same time period, 351 patients were treated with CS, utilizing 522 stents. The average number of stents per patient was 1.48. The total hospital-incurred DES cost was $227,500 for an average stent cost $4945.63 per patient. In the CS group the total cost for stents was $496,050 for an average cost of $1413.25 per patient. The average stent cost per patient was 3.5 times higher in the DES group than with CS. **CONCLUSIONS:** 1) Indications for DES use are consistent with individuals at higher risk for restenosis; 2) the procedural costs for treating these individuals are significantly greater; and 3) full 6 month outcomes and cost data will be available for presentation.

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