therapy of captopril/HCTZ in the treatment of hypertension in Poland. METHODS: To gain data on clinical effectiveness of analyzed therapies the clinical effectiveness analysis based on systematic review of RCTs was conducted. Direct medical costs regarding drug costs and ambulatory treatment, second-line therapy, complications and adverse events valid from public payer perspective were taken into account in the model. Costs data were gained from National Health Fund in Poland and medical experts from cardiology and hypertension. Modelling method applied was a Markov model with a 32 year time horizon. Sensitivity analyses was performed. The analysis were done according to HTA guidelines in Poland. RESULTS: Statistically significant difference in hypertension reduction between ramipril/HCTZ and monotherapy with ramipril or HCTZ was revealed in favour of ramipril/HCTZ. No significant differences in safety profile were found. No significant differences in hypertension reduction were observed in comparison to combined therapy captopril/HCTZ but hypertension control was significantly longer for ramipril/HCTZ treatment. The analysis showed that incremental costs per LYGs were estimated at 1,515 PLN, 6,969 PLN, 13,930 PLN when comparing ramipril/HCTZ with standard therapy of ramipril, HCTZ and captopril/HCTZ respectively. Incremental costs per QALYs were estimated at 1,925 PLN, 8,800 PLN, 13,930 PLN when comparing ramipril/HCTZ with standard therapy of ramipril, HCTZ and captopril/HCTZ respectively. Sensitivity analysis showed that the results of the analysis are robust. CONCLUSIONS: Treatment of hypertension with Tritace comb (ramipril/HCTZ) compared with a standard mono therapy (ramipril, HCTZ) and with combined therapy captopril/ HCTZ is very cost-effective option from the public payer’s perspective in Poland. Incremental costs per LYG and per QALYs are below the acceptable threshold for very cost-effectiveness treatment in Poland (27,000 PLN).

PCV37
ENOXAPARIN IS COST-SAVING AS PROPHYLACTIC THERAPY VERSUS UNFRACTIONATED HEPARIN OR NO PROPHYLAXIS IN HOSPITALISED MEDICAL PATIENTS
Feng J1, Yuen C2, Jackson D3
1IMS Health Australia, St Leonards, Australia, 2Sanofi-Aventis Australia, Macquarie Park, Australia, 3IMS Health Australia, St Leonards, Australia
OBJECTIVES: To evaluate the cost-effectiveness of enoxaparin compared with unfractionated heparin (UFH) or no prophylaxis for prevention of venous thromboembolism (VTE) in hospitalised medical patients from the Australian hospital perspective. METHODS: A hypothetical cohort of hospitalised medical patients was assumed to receive prophylaxis of one of the following: enoxaparin 40 mg once-daily (qid), UFH 5000 IU thrice-daily (tid), UFH 5000 IU bi-daily (bid), no prophylaxis. A decision-analytic model was constructed using clinical trial data and local treatment algorithms. Analysis was conducted for all medical inpatients and a subgroup of patients with ischaemic stroke. The analysis estimated the incidence of VTE (symptomatic DVT and PE), adverse events (heparin-induced thrombocytopenia [HIT], prophylaxis and treatment-related major bleeding), mortality and costs of prophylaxis and treatment within 30 days and one year of initiating prophylaxis. RESULTS: In a cohort of 10,000 patients, at 30 days the estimated number of VTE events was 107 (enoxaparin or UFH tid), 189 (UFH bid) and 292 (no prophylaxis). Estimated numbers of adverse events were 54 (enoxaparin), 198 (UFH tid), 199 (UFH bid) and 49 (no prophylaxis). Estimated total numbers of deaths attributable to prophylaxis, VTE treatment and adverse events were 27 (enoxaparin), 40 (UFH tid), 57 (UFH bid) and 63 (no prophylaxis). Total costs of prophylaxis, diagnostic testing, VTE treatment and adverse event treatment were AUS$1.1 million (enoxaparin), AUS$1.7 million (UFH tid), AUS$1.9 million (UFH bid) and AUS$1.4 million (no prophylaxis). An additional 12 (enoxaparin or UFH tid), 21 (UFH bid) or 32 (no prophylaxis) VTE events were incurred at one year. In patients with ischaemic stroke there was an enhanced effect of enoxaparin versus other therapies, with greater cost savings and incremental outcomes. CONCLUSIONS: Thromboprophylaxis with enoxaparin prevents VTE events and related deaths in medical patients, and simulated cohort analysis demonstrates its cost-saving potential when used instead of UFH.

PCV38
EXTENDED PROPHYLAXIS OF VENOUS THROMBOEMBOLISM (VTE) IN PATIENTS UNDERGOING MAJOR ORTHOPAEDIC SURGERY IN ITALY: A PHARMACOECONOMIC STUDY
Capri S1, Ageno W2, Moia M3, Imberti D4, Palareti G5, Piovela P6, Scannapieco G7, Banfi F8, Pitrelli A9
1Cattaneo-LIUC University, Castellanza, (Varese), Italy, 2University of Insurbia, Varese, Italy, 3Fondazione IRCCS Ospedale Maggiore Policlinico, Milano, Italy, 4Piacenza Hospital, Piacenza, Italy, 5University Hospital of Bologna, Bologna, Italy, 6Fondazione IRCCS Policlinico, Pavia, Italy, 7Azienda ULSS N°9 Treviso, Treviso, Italy, 8GlaxoSmithKline Spa, Verona, Italy
OBJECTIVES: Venous thromboembolism (VTE) is a relevant cause of morbidity and mortality in patients undergoing major orthopaedic surgery (MOS). Thromboprophylaxis is recommended in this setting and low-molecular-weight-heparins (LMWHs) are the anticoagulant agents most frequently used. Fondaparinux is an effective and safe alternative in this setting. Objective of our study was to investigate the cost-effectiveness of fondaparinux versus enoxaparin from the perspective of the Italian National Health Service (NHS) in patients undergoing MOS. METHODS: A decision tree model was developed in order to compare fondaparinux with enoxaparin in extended thromboprophylaxis of patients undergoing MOS. Probabilities of symptomatic events were derived from the results of randomized controlled trials; use of resources in common clinical practice in Italy was evaluated by means of an “ad hoc” questionnaire administered to a panel of experts. Only direct cost of VTE (acute treatment of events and of complications) were included in the analysis. Cost units were derived from current cost of drugs and from Italian National Healthcare tariffs for tests and medical visits in 2007 (in Euros). Incremental Cost-Effectiveness ratios were analysed at three time points: 30 days, one year, five years. RESULTS: After 30 days of extended prophylaxis fondaparinux was associated with a lower cost compared with enoxaparin, leading a saving of €48.83 per patient. At the end of the first year after MOS, the saving is increased to €72.13: rates of late PE and late DVT which are higher with enoxaparin, particularly for patient undergoing total hip replacement (which is the 34% of the population of the model), accounted for this difference. Overall, after 5 years the saving with fondaparinux is €74.36 per patient. Direct cost of prophylaxis is higher with fondaparinux, but this is highly compensated by the different rates of early DVT, early PE and prophylaxis-related major bleeding. One-way sensitivity analysis showed that results were robust to the variation in unit costs for VTE related care or in event rates for both treatments. CONCLUSIONS: The different rates of early and late DVT, PE and prophylaxis-related major bleeding overbalanced the lower cost of enoxaparin, in favour of fondaparinux. Our model suggests that fondaparinux is cost-saving when compared to enoxaparin for VTE prophylaxis in patients undergoing MOS in Italy.