OBJECTIVES: Acute coronary syndromes (ACS) consist mainly of ST-segment elevation myocardial infarction (STEMI) and unstable angina (UA)/non-STEMI (NSTEMI). ACS showed an enormous medical, social, and economic burden worldwide. ACS in the form of myocardial infarction is responsible for almost half of all deaths related to cardiovascular disease. South Korea compared to the OECD country average, shows high cardiovascular morbidity and mortality, and the recurrence rate is increasing every year. We examined the direct cost of hospitalization for ACS which planned percutaneous coronary intervention (PCI) using medical record cost survey in South Korea. METHODS: We conducted a cost survey to examine the actual direct medical costs of the team of cardiologists, technicians of intervention and reimbursement reviewers in the hospital. To examine the cost data of a patient, we received procedures, operations and admissions. We could select index patient cases according to medical chart review as he/she had ever been visited the hospital since last year. Through delphi panel discussion and reviewing, we refined the cost data excluding non-related ACS treatment in index case. RESULTS: It was the first survey of the actual cost in ACS. The total medical cost for ACS patients who have undergone the procedure was 4.451 million Korean won. The cost is lower if considering difficulties in surgery. But among the components in ACS, the cost of stents and devices were largely accounted for the total cost. CONCLUSIONS: The medical cost of ACS in Korea is a burden to both patients and society, due to increasing recurrence in cardiovascular disease. Among the total cost, the cost of stents is higher than the inpatient cost. This is one of the reasons of the high medical cost in this ACS. This result will have implication to the adjust of the cost of stents and devices in ACS treatment in South Korea.

PHARMACIST’S INVOLVEMENT IN A MULTIDISCIPLINARY ISCHEMIC STROKE TEAM IN AND ITS ASSOCIATED COST AVOIDANCE
Tsai YJ, Lee WJ, Lin YM, Lu TH
Shuang Ho Hospital, Taipei Medical University, New Taipei, Taiwan, Taiwan

OBJECTIVES: Stroke is a major cause of death around the world. This study aims to evaluate the quality of care in pharmacist’s participation in a multidisciplinary ischemic stroke team, and the potential cost avoidance associated with the recommendations made by clinical pharmacists. METHODS: We conduct a retrospective study. The primary outcome was to determine the pharmacist's impact on medication costs of ischemic stroke patients. We included 86 stroke patients (1:1) matched for age, gender, risk factors, NIHSS, mRS, Barth index, education, and severity of stroke. Data collection was from November 2007 to September 2010. The patients with hemorrhage stroke are excluded from sample. Quality of stroke care was assessed by five pharmaceutical care-related performance indicators, which are: the measured probability of harm. To evaluate cost-effectiveness of adding ezetimibe to simvastatin for high CHD risk patients who cannot attain treatment goal (LDL-C ≥ 100 mg/dL) on their current simvastatin dosage from Thai payer perspective. METHODS: A published Markov model (Cook et al. 2008) was used to project lifetime costs and outcomes of lipid-lowering treatment in primary and secondary CHD prevention. Lipid efficacy data were obtained from clinical trials. Risks of CHD events and non-CHD related mortality rates were estimated by using Framingham Heart Study risk equations and information from Ministry of Public Health (MOPH), respectively. Discounted costs and outcomes were calculated from the published literature. Drug prices were those published by MOPH. All costs were expressed in THB 2010 values. Future costs and outcomes were discounted at 3%. Two scenarios were compared in the analysis: the addition of ezetimibe to simvastatin 20 mg versus switching to rosuvastatin 10 mg and the addition of ezetimibe to simvastatin 40 mg with switching to atorvastatin 40 mg, respectively. CONCLUSIONS: Ezetimbe co-administration increased life expectancy (LY) by 0.15 and 0.26 years and resulted in 0.07 and 0.12 additional quality-adjusted life years (QALY) when compared to a switch to rosuvastatin and a switch to atorvastatin, respectively. The QALY gained would yield lifetime cost-savings of Baht 1,106 and 2,137 per patient for such comparisons. Similar results were obtained when costs and outcomes were either discounted or undiscounted. The sensitivity analyses showed that results were robust to changes across scenarios. CONCLUSIONS: This analysis suggests the addition of ezetimibe to lipid-lowering treatment strategy (more effective and less costly) in both scenarios. The results are very imperative to assist policy decision-making in order to increase access to second-line treatment option for patients not achieving lipid treatment goals with simvastatin monotherapy in Thailand.