morbidty and mortality is highly desirable. Elevated albuminuria levels have proven to predict worse cardiovascular outcomes. The aim of our study was to estimate the cost-effectiveness and of a population-based ‘screen-and-treat’ procedures directed at albuminuria. METHODS: A formal cost-effectiveness analysis was conducted using a Markov-model for disease progression. The model consist of 8 health states defined by urinary albumin excretion (UE) classification (UE < 15 mg/day (low-normo), UE 15–30 mg/day (high-normo), UE 30–300 mg/day (micro), ≥300 mg/day (macro)), cardiovascular morbidity, cardiovascular mortality, non-cardiovascular mortality and renal disease (e.g. dialysis). Input-variables for transitions between albuminuria-based Markov stages and effects of blood pressure lowering agents were derived from the observational PREVEND cohort study and PREVEND-IT clinical trial. All costs were presented in 2008 values and the cost-effectiveness analysis was performed following the Dutch guidelines for conducting pharmacoeconomic research. RESULTS: Early results for screening the Dutch population on albuminuria (≥15 mg/day) and subsequent ACE-inhibitor treatment in those found positive, suggests a crude cost-effectiveness of €29,300 per life year gained (LYG). Treating only those subjects with microalbuminuria (≥30 mg/day) resulted to be more favorable with a cost-effectiveness of €9,700 per LYG. Furthermore, restricting screening to only those subjects aged >50 or >60 years resulted in a cost-effectiveness of respectively €15,000 and €10,200 per LYG. These age-dependent figures were even more favorable in those subjects with microalbuminuria. Our preliminary results suggest a favorable cost-effectiveness outcome below the (informal) Dutch pharmaeconomics threshold of €20,000 per LYG. CONCLUSIONS: Next to the cost-effectiveness outcomes from the PREVEND-IT economic evaluation, our results on observational data suggest favorable cost-effectiveness outcomes for a population-based ‘screen-and-treat’ procedure on albuminuria. Definite results including probabilistic sensitivity analyses will be presented during the conference.

MODIFIED COST-EFFECTIVENESS OF ACHIEVING MULTIPLE LIPID TARGETS WHEN FENOPIRUC ACID IS CO-ADMINISTERED WITH SIMVASTATIN, ROSUVASTATIN, AND ATORVASTATIN

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OBJECTIVES: To compare the short-term cost-effectiveness of simultaneously achieving multiple lipid targets when fenofibric acid (FA) is co-administered with simvastatin, rosuvastatin, and atorvastatin. METHODS: A dyslipidemia outcomes model was used to estimate multiple lipid goal attainment (any 3 of 4 targets: total-C, LDL-C, HDL-C, TG) and associated costs over one year in a patient cohort with multiple lipid abnormalities. Lipid goal threshold values were based on U.S. clinical practice guidelines. Baseline lipid values and lipid efficacy data were obtained from three 12-week FA/statin studies, where FA 135 mg co-administered with atorvastatin, rosuvastatin, and simvastatin at low (20 mg, 10 mg, 20 mg, respectively) and moderate doses (40 mg, 20 mg, 40 mg, respectively) was compared to FA and equivalent doses of each statin monotherapy. Net drug costs were estimated. Drug costs were based on wholesale acquisition costs and were assumed additive. Patient copays were based on national averages. RESULTS: The predicted rate per 1,000 patients achieving 3 lipid targets with the co-administration of FA and low-dose simvastatin, rosuvastatin, and atorvastatin was 678, 814, and 723, respectively. Per member per month drug costs for each low-dose combination were estimated at $24.09, $39.63, and $41.40, respectively. The estimated per patient costs per three lipid goals achieved were $1279, $1753, and $2062 for each respective low-dose combination. The incremental cost effectiveness ratio (ICER) for one additional patient achieving 3 lipid targets when FA is combined with low-dose rosvastatin and atorvastatin relative to simvastatin is $4,113 and $13,849, respectively. For the moderate-dose combinations, qualitative results are similar though ICERS versus simvastatin for rosvastatin and atorvastatin were 1.4–11.2 times higher, respectively. CONCLUSIONS: Adding FA 135 mg to simvastatin 20 mg and 40 mg yields the lowest annualized cost per patient achieving 3 lipid targets compared to equivalent dose combinations of FA with rosuvastatin and atorvastatin.

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COST-EFFECTIVENESS OF EPLEORENILE IN PATIENTS WITH HEART FAILURE AFTER ACUTE MYOCARDIAL INFARCTION

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OBJECTIVES: In the Eplerenone Post-Acute Myocardial Infarction Heart Failure Efficacy and Survival Study (EPHESUS),
these patients.

In addition to standard therapy, eplerenone prevents events, saves hospitalization resources and improves survival among patients.

Efficacy data from EPHESUS study during the 16 month follow-up period were used. Survival data beyond trial period were estimated from the Framingham Heart Study Registry. The study was carried out from societal perspective; therefore, only direct medical costs where included. Drug acquisition costs were priced at AWP (average wholesale price), €2007. Costs were obtained from Spanish databases. Costs and effects were discounted 3% annually. Sensitivity analyses were carried out based on alternative life-years gained estimates from the Saskatchewan Health database and Worcester Heart Attack Registry Data, (0.0636 and 0.1337 respectively). RESULTS: The number of LYG with eplerenone was 0.1014 based on Framingham. Cost was €1016.90 higher over the trial period in the eplerenone arm because of drug cost (€1,164.07). The Framingham incremental cost-effectiveness ratio (ICER) of eplerenone compared to placebo was 10,030€ per LYG and 15,047€ per QALY gained. Sensitivity analyses showed eplerenone was efficient under alternative life expectancy estimates: €15,996 per LYG with Saskatchewan and €7,606 per LYG with Worcester. CONCLUSIONS: Selective aldosterone blockade with eplerenone is a cost-effective strategy in post-AMI patients with heart failure in Spain. In addition to standard therapy, eplerenone prevents events, saves hospitalization resources and improves survival among these patients.

ECONOMIC EVALUATION OF AN ABDOMINAL AORTIC ANEURYSM SCREENING PROGRAM

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OBJECTIVES: Abdominal Aortic Aneurysm (AAA) is defined as a localized dilatation of aortic vessel. It’s predominantly asymptomatic, but represents a chronic degenerative condition associated with life-threatening risk of rupture. The early diagnosis of AAA, i.e. before its ruptures, is therefore important and ultrasound examination is a simple and effective method for this. To assess benefit of screening in Italy we developed a cost-effectiveness Markov model comparing screening vs non-screening scenario. METHODS: We considered a patient cohort composed of 65 years old men screened for AAA in the Italian NHS perspective and compared it to a non-screened population. We collected data both from literature and from a real screening program that is on-going in San Martino Hospital in Genova. The following health states were distinguished: no AAA, unknown small-AAA (3–3.9 cm), followed-up small-AAA (1 year), unknown medium-AAA (4–4.9 cm), followed-up medium-AAA (6 months), unknown large-AAA (>5 cm), elective repair, emergency repair, electively repaired AAA, emergency repaired AAA, rejected large AAA and death. Transition between health states were simulated using 6-month cycles. Incremental cost per life year saved was calculated for a 35-year time horizon and applying a 3% discount rate to both cost and benefits. RESULTS: Considering an attendance rate of 70%, the individual cost per invited subject was €104.42. 0.024 additional life years was gained per patient in the screened cohort, corresponding to an ICER of €4363/LYS. Univariate and multi-variate sensitivity analyses were performed for all parameters. The results were not sensitive to changes in parameters and suggest that screening for AAA is cost-effective with a probability approaching 100% based on a willingness-to-pay threshold of €30,000. CONCLUSIONS: Similarly to economic evaluations developed in other countries like UK, Canada, etc, the setting up of a screening program for AAA can be considered to be cost-effective in the Italian NHS perspective.

ENHANCING SYNCOPE DIAGNOSTICS:

COST-EFFECTIVENESS ANALYSIS OF AN IMPLANTABLE LOOP RECORDER STRATEGY VERSUS THE STANDARD OF CARE

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OBJECTIVES: Recent progress has enabled physicians to meet the challenge of syncope diagnosis and provide faster and better guided treatment to the patient. Syncope investigation traditionally included loosely-defined combinations of ECGs, Holter Monitors, Tilt Tests, EP Studies and Imaging Diagnostics. While tests were being performed, patients remained at risk of death, falls and fractures. We wanted to examine the potential cost-effectiveness of adding an Implantable Loop Recorder to the traditional clinical pathway. Clinical evidence increasingly demonstrates that ILR-enhanced diagnostics may enable physicians to achieve more clear diagnoses, at a fraction of the time. METHODS: We developed a decision-analytic model in

Abstracts

PCV46

COST-EFFECTIVENESS OF CLOPIDOGREL IN MYOCARDIAL INFARCTION WITH ST-SEGMENT ELEVATION: A SPANISH MODEL BASED ON THE CLARITY AND COMMIT TRIALS

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OBJECTIVES: Clopidogrel has shown to be cost-effective to prevent ischemic events in non-ST segment elevation acute coronary syndromes (NSTEMACS). This study is intended to assess the cost-effectiveness of clopidogrel in long-term treatment of ST-segment elevation myocardial infarction (STEMI) in Spain.

METHODS: A combined decision tree and Markov model was constructed. Efficacy data was obtained from CLARITY and COMMIT trials for the first month, and the “CAPRIE-like” cohort of CHARISMA trial (months 2–12). The risks of death, myocardial infarction, and stroke in an untreated population and long-term survival after all events were derived from the Swedish Hospital Discharge and Cause of Death register. A payer perspective was chosen for the analysis, using local costs. Effectiveness was measured as the number of life-years gained (LYG) with clopidogrel treatment. Costs and effects were discounted at 3%.

RESULTS: The difference in stroke rates was more pronounced in CLARITY (0.9% vs. 1.7% and 0.55% vs. 0.62% in the CLARITY and COMMIT respectively) and thus facilitates important cost savings. In two patient cohorts with the same characteristics and event rates as in the CLARITY and COMMIT population, treatment with clopidogrel for up to 1 year opposed to treatment with ASA resulted in ICERS (€LYG): in CLARITY cohort €397 and in COMMIT cohort €2927. CONCLUSIONS: Treatment of STEMI patients with clopidogrel appeared to be cost-effective in long-term with predicted ICERS below generally accepted threshold value of €30,000/LYG.