intraocular pressure (IOP)-lowering efficacy in patients with open-angle glaucoma. The purpose of this study was to carry out a cost-effectiveness analysis of latanoprost versus timolol, bimatoprost and travoprost in the treatment of glaucoma in Spain. METHODS: A cost-effectiveness analysis was performed by building a decision analytical model. Effectiveness data (treatment success was defined as patient with successful IOP control: ≤18 mmHg) were obtained from published clinical trials measuring IOP-lowering of drugs under evaluation. Health care resource utilization was taken from the aforementioned clinical trials and a local expert panel. Only direct medical costs were included in the model (drug acquisition, diagnostic procedures, ophthalmologist visits and treatment of therapeutic failures). Drug acquisition cost data were obtained from official sources while the rest of the data were taken from a national health care costs database. The perspective selected for this analysis was the National Health Service and the time horizon chosen was for 6 months, the time that patients were included in most of the clinical trials found. RESULTS: Cost per patient associated with the use of timolol, latanoprost, bimatoprost and travoprost was 368€, 379.5€, 377€, and 383€, respectively while their cost/effectiveness ratio was 1116, 702, 785, and 912€ per each patient with a treatment success. The incremental cost-effectiveness ratio of using latanoprost compared to timolol, bimatoprost and travoprost was 54, 40, and 32€ per each additional patient achieving optimal IOP control. CONCLUSIONS: The results of this pharmacoeconomic model demonstrates that latanoprost is a more cost-effective option than the rest of evaluated alternatives. Therefore, latanoprost should be considered as the therapeutic option to be selected routinely in the treatment of open-angle glaucoma in Spain.

PE65

COST EFFECTIVENESS OF LATANOPROST IN FIRST LINE TREATMENT OF PRIMARY OPEN ANGLE GLAUCOMA IN THE UK

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OBJECTIVES: To estimate the cost effectiveness of first-line latanoprost treatment for POAG compared with beta-blockers, travoprost or bimatoprost using a previously developed economic model. METHODS: A decision analytical model was developed where POAG patients either receive latanoprost, beta-blockers, travoprost or bimatoprost as first-line therapy. Subsequent therapy switches were determined by average time that patients persisted with each therapy. Persistency data was obtained from a retrospective cohort study (Reardon, 2004). IOP controlled days are estimated from this by assuming that switch-overs from one therapy to another occurs only when the maximum IOP (18 mmHg) is not achieved. Resource use was obtained from UK expert opinion and was abstracted beginning with initial low vision visit. Clinical data collected included: patient demographics, baseline medical and surgical costs. Overall treatment costs are higher for travoprost (£29,597 more) and bimatoprost (£36,650 more) compared with first-line latanoprost therapy due to higher rates of subsequent therapy and surgery. CONCLUSIONS: Overall, compared to other prostaglandins and beta-blockers, latanoprost first-line therapy results in greater benefit to patients in terms of more days of IOP control. Latanoprost first-line therapy compared with travoprost and bimatoprost results in greater persistency and lower costs.