initial surgical procedure, and an incremental cost after one year of £43.70. QALYs were 0.7675 and 0.7591 (PPH vs. MM, respectively). The ICER for PPH vs MM was estimated at £3188.09 per QALY. Probabilistic sensitivity analysis demonstrated the results to be robust. CONCLUSION: PPH is a valuable alternative to MM in patients where surgical intervention is indicated. Efficacious without compromising QoL, whilst decreasing length of stay and OR time, PPH can be considered a cost-effective procedure for prolapsed internal haemorrhoids.

THE RELATIVE COST-EFFECTIVENESS OF THE FENTANYL HCL PATIENT-ACTIVATED TRANSDERMAL SYSTEM (ITS) IN ACUTE POST-OPERATIVE PAIN MANAGEMENT (POPM) IN GREECE

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OBJECTIVES: This study evaluated the cost-effectiveness of ITS versus current POPM choices in Greece from the hospital perspective.

METHODS: Two hundred, forty-nine surgeons and anesthesiologists were interviewed to derive the most frequent treatment sequences for POPM in patients experiencing moderate to severe post-surgical pain. These were: a) 2 days intravenously administered (IV) opioids, 2 days IV non opioids, 1 day oral non-opioids; b) 2 days intramuscularly administered (IM) opioids, 2 days IV non-opioids, 1 day oral non-opioids; c) 2 days epidural, 3 days oral non-opioids. A decision analytic model was developed to estimate costs and effectiveness of each of these sequential treatment arms, from surgery to discharge, compared with 2 days of ITS followed by 3 days of oral non-opioids. Effectiveness data were obtained from ITS trials and published literature. The resource utilisation was defined by the same physician interviews and a Delphi Panel of 40 Greek physicians.

RESULTS: The probability of a successful treatment (adequate pain control and no complications) was 76% for ITS, 49% for the first two treatment sequences and 72% for the third. Total cost per patient was €777–€717€ for ITS and €717, €704, €770 for the three sequences respectively. ITS was associated with reduced staff time and fewer complications. The model was robust with low-moderate sensitivity (±10% change of base results). CONCLUSION: The treatment sequence of ITS dominated the currently practiced POPM treatments in Greece indicating that ITS cost was offset by savings resulting from reduced staff time and fewer complications.

THE EFFECTS OF LAPAROSCOPIC SURGERY AND NOSOCOMIAL INFECTIONS ON THE COST OF CARE: EVIDENCE FROM THREE SURGICAL PROCEDURES

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OBJECTIVES: Evidence on the health care costs of laparoscopic versus open surgery remains inconclusive. Previous work has largely used charge data to measure cost, whereas a more relevant metric would be the actual transactions amounts paid. While studies have quantified the association between surgical site infections (SSI) and cost, there is little evidence on the broader measure of nosocomial infections (SSI, UTI, blood and respiratory infections). To address these issues, this study examined the effects of laparoscopic versus open surgery and nosocomial infections on direct health care costs for three common surgical procedures: cholecystectomy, hysterectomy, and appendectomy.

METHODS: Hospital discharge abstract data were obtained for 4489 subjects in 10 hospitals who were treated for cholecystectomy, hysterectomy, or appendectomy via laparoscopic or open procedures. Multivariable regression analyses were performed to estimate the relationships between laparoscopic surgery, nosocomial infections and health care costs for these three procedures. The models also controlled for the following confounders: disease severity, age, gender, insurance status and hospital. RESULTS: Laparoscopic surgery significantly reduces the cost of these surgical procedures. For all patients, laparoscopic surgery reduces the health care costs of surgery by $1796 (p < 0.01). For cholecystectomies alone, laparoscopic surgery reduces these costs by even more—$2457 (p < 0.01). Laparoscopic surgery reduces costs for hysterectomy by $1888 (p < 0.01) and appendectomy by $1019 (p < 0.05). Nosocomial infections have a large and significant effect on costs, increasing overall costs by $3591 (p < 0.01). The increased costs of nosocomial infections are greatest for cholecystectomies ($5009, p < 0.01), followed by appendectomies ($3185, p < 0.01) and hysterectomies ($2581, p < 0.01). CONCLUSION: Laparoscopic surgery and nosocomial infections are major cost drivers for each of these procedures. Laparoscopic surgery substantially reduces the costs to payers for cholecystectomies, hysterectomies, and appendectomies; whereas nosocomial infections have a large positive effect on transaction costs for all three procedures.

RETROSPECTIVE STUDY OF COMPLICATIONS AND RESOURCE USE IN ENDOVASCULAR MANAGEMENT OF AAA

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OBJECTIVES: In abdominal aortic aneurysm (AAA) an endovascular procedure (EVAR) was introduced challenging the gold standard of open repair (OR). RCTs comparing them from 1999 onwards showed benefit in 30-day mortality for EVAR. Due to additional experience with EVAR; complication rates and resource consumption may have improved. The aim of this study is to assess the efficacy, safety and resource use in the first year post EVAR in a current population compared to the EVAR populations included in RCTs. METHODS: Efficacy, safety and resource use data were collected retrospectively for patients undergoing EVAR from 2004, with at least one year follow-up. Patient population was designed to match the published trials in terms of age, AAA size, and suitability for surgery. Descriptive statistics were used with normative data, mean, minimum and maximum value, number of patients with valid data and 95% confidence intervals calculated for continuous and frequencies for discrete data. RESULTS: A total of 149 patients’ records from UK and Dutch hospitals were analyzed. Patients in the study were similar in terms of age and gender to the published trials, but higher proportion had additional risk factors (diabetes,