COSTS OF ACUTE MYOCARDIAL INFARCTION IN HUNGARY;
2003–2005
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OBJECTIVE: The morbidity of acute myocardial infarction (AMI) is remarkable in Hungary, therefore it is inevitable to understand the disease burden more accurately. Our aim was to assess the burden of AMI in Hungary between 2003 and 2005. We studied how much burden AMI patients impose on the financial (National Health Insurer Fund Administration—NHIFA) in the inpatient and outpatient care and we estimated the size of indirect social costs, too. METHODS: We extracted the data of ‘new’ AMI patients (ICD-10: I21 main diagnosis but not treated with the same diagnosis in the previous 24 months) hospitalized in May 2003 from the database of the financier. We analyzed inpatient treatment costs of these patients in the period of 12 months before theAMI and in the following first and second 12 months. Data were distributed by sex and age (age groups: 25–44, 45–64, over 65). Other costs were estimated after expert consultations. RESULTS: Average health insurance costs of AMI’s active hospital care in the first 12 months are generally higher in females as in males; €1905.2 vs. €1564.4 (65 and over), €1716.4 vs. €1557.6 (45–64) and €918.0 vs. €962.4 (25–44). The burden in the chronic care is €60–160 per patient in the first year, which is similar to the active care costs in the 23rd to 24th months after theAMI (€88–216). CONCLUSION: NHIFA was estimated to spend 17.6 million Euros on direct health care on behalf of the nearly 12,000 annual AMI patients in the first 12 months. Avoiding one AMI could save €1380–2260 (depending on gender and age) direct health care cost in the first 12 months. According to our estimate, the annual indirect costs of AMI exceed €3.36 million (€711.3/patient) in the working age group.

LIKELIHOOD AND COST OF ADVERSE EVENTS IN ATRIAL FIBRILLATION ARE ASSOCIATED WITH CHOICE OF ACUTE CONVERSION THERAPY
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OBJECTIVE: We evaluated the likelihood and cost of adverse events (AE) by choice of acute conversion therapy for atrial fibrillation (AF) in hospitalized patients. METHODS: We extracted Premier Perspective(tm) 2004–2005 discharges with primary AF diagnosis and treatment with electric conversion (EC) or IV anti-arrhythmic agent (AA; either amiodarone, ibutilide or procainamide). We estimated odds ratios and inpatient costs attributable to any AE, hypotension AE, or dysrhythmia AE based on treatment, adjusting for comorbid, demographic and hospital-specific factors. RESULTS: Out of 74,072 discharges initially treated with EC (32%), amiodarone (49%), ibutilide (11%) or procainamide (8%), approximately 28% (20,808) had a treatment-related AE. Of these, 24% had hypotension and 37% experienced dysrhythmia. Odds ratios for any AE were significantly higher when initial treatment was amiodarone vs. EC (OR; 95% CI) (1.24; 1.20–1.29), amiodarone vs. procainamide (1.36; 1.27–1.46) and amiodarone vs. ibutilide (1.58; 1.48–1.68). A similar pattern was observed for hypotension AE. Initial treatment with EC increased the likelihood of dysrhythmia AE vs. amiodarone (1.23; 1.16–1.30), ibutilide (1.21; 1.11–1.33) and procainamide (1.29; 1.16–1.44). Adjusted costs for discharges with any AE were significantly higher vs. discharges without AE (P < 0.0001). AE among patients receiving an AA had the highest cost impact, contributing an average of $2702 in additional adjusted costs. Hypotension and dysrhythmia AE among patients receiving AA were associated with $1232 and $1054 in additional adjusted costs, respectively (P < 0.0001). Among patients receiving EC, any AE, dysrhythmia and hypotension AE were associated with $2128 (P < 0.0001), $1655 (P < 0.0001) and no significant (P = 0.21) increase in costs, respectively. CONCLUSION: The likelihood of AE is associated with choice of initial AF therapy. Patients initially treated with amiodarone have the highest likelihood of AE, particularly hypotension AE; those treated initially with EC have a higher likelihood of dysrhythmia AE. Incremental costs attributable to AE are substantial in this population.