The cost savings following the use of iodixanol compared to lipiodol in coronaryography averaged 2287 RUB (72 USD) in common population, 2866 RUB (USD91) in patients with CKD, and 3427 RUB (US$109) in patients with diabetes mellitus and CKD. CONCLUSIONS: The results of this study demonstrated iodixanol to be cost-savings compared to low-osmolar contrast media both in risk groups and in general population.

PCVS8
TRIAL-BASED ECONOMIC ASSESSMENT ALONGSIDE THE TCTVB (TAKE CONTROL OF YOUR BLOOD PRESSURE) TRIAL
Reed SD, Li Y, Oddone EZ, Neary AM, Orr MM, Grabber JM, Graham FL, Olsen MK, Swetkay LP, Dolor RJ, Powers BJ, Adams MB, Bosworth HB
'Duke Clinical Research Institute, Durham, NC, USA, 'Duke University Affairs Medical Center, Durham, NC, USA, 'Duke University Medical Center, Durham, NC, USA
OBJECTIVES: The Take Control Of Your Blood Pressure trial randomized 663 community-dwelling individuals with hypertension to evaluate the impact of a telephonic behavioral self-management intervention, home blood pressure monitoring, and both interventions combined compared to usual care on reducing systolic blood pressure (SBP) over 24 months. At 24 months, the combined intervention demonstrated a significant 3.9 mmHg (95% CI: 0.56, 7.9) reduction in SBP relative to usual care. Patients randomized to home BP monitoring or the behavioral intervention had less improvement (0.6 mmHg and -0.6 mmHg, respectively). A prospective economic evaluation was performed. METHODS: Measures of medical resource use costs were derived from electronic data representing medical care delivered within the Duke University Health System. Intervention-related costs, including patient time, were estimated using patient-level data collected during the trial, administrative records, and published unit costs. Sensitivity analyses were conducted to evaluate the impact of changing assumptions about overhead costs and time between completed phone encounters when estimating costs associated with the behavioral intervention. RESULTS: On average, over 24 months, patients incurred $6,965 (SD = 22,034) in inpatient costs and $8,676 (SD = 9,368) in outpatient costs, with no significant differences across intervention groups. When applying base-case assumptions, 24-month intervention costs were estimated to be $90 (SD = 2) for home blood pressure monitoring, $345 (SD = 64) for the behavioral intervention ($31 per phone encounter) and $416 (SD = 93) for the combined intervention. In sensitivity analyses, the cost for each phone encounter ranged from approximately $10 to $45. Patient time costs were estimated at $385 (SD = 487) for home blood pressure monitoring and $741 (SD = 29) for the combined intervention. CONCLUSIONS: Home blood pressure monitoring and/or the behavioral intervention had little impact on medical resource use or costs over 2 years. Our analysis demonstrated that these interventions are cost-additive to the health care system and that patients’ time costs are considerable.

PCVS9
ECONOMIC ANALYSIS OF THE ENDEAVOR DRUG-ELUTING STENT VS. THE DRIVER BARE METAL STENT: RESULTS FROM THE ENDEAVOR II TRIAL
Essien EN, Edwards R, Cowper PA, Kong DP, Silverstein MD, Mark DB, Anstrom KJ, Wijns W
'Duke Clinical Research Institute, Durham, NC, USA, 'Health Care Research, Belcare, TX, USA, 'Cardiovascular Center, Aalst, Belgium
OBJECTIVES: To assessed the economic attractiveness of the Endeavor drug-eluting stent (DES) vs. the Driver bare metal stent (BMS) using a 4-year follow-up information from the DEBATE II clinical trial. METHODS: We used clinical, index procedure and follow-up events data from subjects randomized to receive Endeavor (n = 598) vs. Driver (n = 599), and applied Medicare cost and quality of life adjustments from secondary sources. We compared differences in clinical endpoints, medical costs, and quality adjusted survival through 4 years follow-up (1440 days). RESULTS: There were no differences in both treatment groups had similar baseline characteristics. The use of Endeavor vs. Cypher drug-eluting stents (DES) in the ENDEAVOR II clinical trial. METHODS: We analyzed case report form information from subjects randomized to receive Endeavor (n = 323) vs. Cypher (n = 113) stents, using quality of life adjustment and Medicare cost weights applied from secondary sources, and a $2100 cost for stents. We compared differences in outcomes and costs; and evaluated cost-effectiveness through 3 years follow-up (1080 days). RESULTS: The use of Endeavor vs. Cypher stents reduced the 3-year rates of 100 subjects of death or myocardial infarction (MI) by 0.8; difference, 6.9, 95% confidence interval (CI) –0.8 to 9.9; p = 0.283, with no difference in target vessel revascularization rates (17.9 vs. 12.2; difference, 5.7; 95% CI, –1.9 to 13.1; p = 0.23), but greater use of coronary artery bypass graft surgery (3.3 vs. 0.0; difference 3.3; 95% CI, 1.3 to 5.7; p = 0.002). After discounting at 3% per annum, total medical costs for Endeavor vs. Cypher were similar ($23,353 vs. $21,657; difference, $1696; 95% CI, $–1089 to $4482; p = 0.23), and the 3-year cost-effectiveness ratio was $57,002 per quality-adjusted life year. CONCLUSIONS: Use of Endeavor vs. Cypher drug-eluting stents (DES) in the ENDEAVOR II clinical trial randomized 663 community-dwelling individuals with hypertension to evaluate the impact of a telephonic behavioral self-management intervention, home blood pressure monitoring, and both interventions combined compared to usual care on reducing systolic blood pressure (SBP) over 24 months. At 24 months, the combined intervention demonstrated a significant 3.9 mmHg (95% CI: 0.56, 7.9) reduction in SBP relative to usual care. Patients randomized to home BP monitoring or the behavioral intervention had less improvement (0.6 mmHg and -0.6 mmHg, respectively). A prospective economic evaluation was performed. METHODS: Measures of medical resource use costs were derived from electronic data representing medical care delivered within the Duke University Health System. Intervention-related costs, including patient time, were estimated using patient-level data collected during the trial, administrative records, and published unit costs. Sensitivity analyses were conducted to evaluate the impact of changing assumptions about overhead costs and time between completed phone encounters when estimating costs associated with the behavioral intervention. RESULTS: On average, over 24 months, patients incurred $6,965 (SD = 22,034) in inpatient costs and $8,676 (SD = 9,368) in outpatient costs, with no significant differences across intervention groups. When applying base-case assumptions, 24-month intervention costs were estimated to be $90 (SD = 2) for home blood pressure monitoring, $345 (SD = 64) for the behavioral intervention ($31 per phone encounter) and $416 (SD = 93) for the combined intervention. In sensitivity analyses, the cost for each phone encounter ranged from approximately $10 to $45. Patient time costs were estimated at $385 (SD = 487) for home blood pressure monitoring and $741 (SD = 29) for the combined intervention. CONCLUSIONS: Home blood pressure monitoring and/or the behavioral intervention had little impact on medical resource use or costs over 2 years. Our analysis demonstrated that these interventions are cost-additive to the health care system and that patients’ time costs are considerable.

PCVS10
IDENTIFYING DRIVERS OF POST-HOSPITAL DISCHARGE FOR PATIENTS WITH ACUTE CORONARY SYNDROME (ACS) USING QUANTILE REGRESSIONS
Dogan N, Winget M
Ell Lilly and Company, Indianapolis, IN, USA
OBJECTIVES: To identify drivers of post-hospital costs among ACS patients, including treatment type received. Patients who are hospitalized with ACS have different treatment options, including revascularization procedures. Treatment options are expensive, there might be offsets in future health care costs by preventing adverse coronary events. METHODS: We studied commercially insured individuals, aged 18–64, with 36 months continuous enrollment in a large, geographically diverse health plan between January 2003 and December 2006. Patients were identified if they were hospitalized between January 1, 2004 and December 31, 2005, with a diagnosis of ACS. A 1 year follow-up period was used and costs incurred after patients’ initial hospital discharge were examined. In addition to ordinary least squares (OLS), quantile-regression models (QRM) were used to identify drivers of post-hospital costs. QRM make no assumption about the distribution of the error term and provide quantile-specific covariate effects, which is useful in applications with highly skewed data. RESULTS: OLS results indicated co-morbidity scores, prior health care costs and initial hospital diagnosis were main drivers of post-hospital discharge costs (p < 0.01). Also, revascularization procedures during the initial hospitalization were not significantly associated with post-hospital costs. QRM confirmed the other findings but showed, at the lower end of the post-hospital costs distribution, having revascularization procedures during the initial hospitalization was significantly associated with higher post-hospital costs. This effect was not significant in the upper quantiles. CONCLUSIONS: In this study, initial hospital diagnosis, higher co-morbidity scores and prior health care costs were associated with higher post-hospital costs. Also, QRM showed revascularization procedures were drivers of cost for patients with lower post-hospital expenditures. This is an intuitive finding considering patients who have revascularization procedures may have more follow-up care compared to those without revascularization. However, these patients may have fewer secondary events requiring hospitalization, thus keeping them in the lower cost quantiles.