and treating osteoporosis in postmenopausal women (PW). In addition, these are the first option of treatment (the Spanish Bone and Mineral Society -SEIOMM) in the Clinical Practice Guidelines (GPC) (2003). Here, we analyse the evolution of consumption of bisphosphonates and raloxifene in Spanish PW (over 50), during the period 1999 to 2004. METHODS: A retrospective analysis of the consumption was made, selecting the four drugs for osteoporosis in PW treatment. Paget’s disease data were not included. Drug consumption data were provided by the Ministry of Health and Consumer Database. The figures are presented as number of dispensed units (standard package), as numbers of DDDs / 1000 PW / day, according to the ATC/DDD system, Index 2006, and as Euros (Price to Customer tax-free) / Dispensed DDDs / 1000 PW / day. Demographics were consulted in the Spanish INE Database. RESULTS: The number of dispensed units of Alendronate, Risedronate and Raloxifene between 2003 and 2004 were 43.41%, 126.62%, and 19.75%, respectively. Only Etidronate decreased, but only a 9.64%. From among the results to emphasize the figures of DDDs / 1000 PW / day between 2003 and 2004 that show also this increase (15.87%, 60.18%, and 1.45% for Alendronate, Risedronate and Raloxifene, respectively). Alendronate presented the highest cost in 2004 (£12297.15/DDD / 1000 PW /day. CONCLUSIONS: The indicators used in this study have permitted establish that dispensing data of osteoporosis in PW treatment financed by Spanish NHS had a significant increase in 2004. These data coincide with the implementation of the Spanish GPC.

**THE ESTIMATION OF COST-EFFECTIVENESS THRESHOLDS PRIOR TO THE START OF LARGE CLINICAL STUDIES**

Van Sta TP¹, Cooper C², Leufkens HG²

¹General Practice Research Database, London, UK, ²University of Southampton, Southampton, UK, ³Utrecht University, Utrecht, The Netherlands

OBJECTIVES: Cost-effectiveness analyses are currently conducted after the conduct of expensive clinical trials. An approach was developed to estimate cost-effectiveness thresholds prior to clinical studies, comparable to statistical power calculations. METHODS: A new osteoporosis treatment was taken as example, with different scenarios of treatment efficacy and costs. Data on fracture and mortality risks were obtained from the General Practice Research Database. These risks were estimated individually by age, sex, fracture history, body mass index, smoking and other risk factors. EQ5D utilities were obtained from a UK national report (NICE) and outcomes were simulated over a 10-year period (5-year treatment), using a cost-acceptability ratio of £30k per QALY gained. RESULTS: The 5-year risk of osteoporotic fracture required to reach the cost-effectiveness threshold was 17.1% (95% confidence interval 15.0–19.3%) with a fracture efficacy of 0.50 at an annual cost of £1000. This was 6.1% (5.2–7.0%) with a cost of £250 and 3.7% (3.1–4.5%) with a cost of £100. With a fracture efficacy of only 0.80, these threshold risks were 34.7% (23.2–38.7%), 10.7% (8.3–14.5%) and 5.4% (3.8–7.8%), respectively. At a T-score of −2.5 and fracture efficacy of 0.80 and cost of £250, patients without a fracture history would require additional risk factors (with a relative rate of 2.5) in order to reach the threshold, which this would be reached by the average woman at age 85. However, with a cost of £1000, this threshold would only be reached at age 55 with additional risk factors with RR of 9.5 and at age 85 with RR of 3.0. CONCLUSION: Cost-effectiveness thresholds can be estimated prior to expensive clinical trials using high-quality health care databases. Similar to statistical power calculations, they can then be used to guide patient selection into the clinical trials, by providing information on the required minimum levels of risks.