COST-EFFECTIVE situation was maintained in all sensitivity analyses. In deterministic analyses, the cost-utility ratio of adding bosentan, INHI or no active treatment (NAT) to palliative care, for patients with PAH of functional class (FC) III in Finland than either INHI or NAT.

OBJECTIVES: Pulmonary Arterial Hypertension (PAH) is a devastating disease, which has a significant impact on patients’ quality of life and mortality. Both bosentan and inhaled iloprost (INHI) have demonstrated prolonged survival in long-term observational studies. We assessed the cost-effectiveness of adding bosentan, INHI or no active treatment (NAT) to palliative care, for patients with PAH of functional class (FC) III in Finland. METHODS: A cost-utility model simulated hypothetical patients with PAH, using a lifetime horizon and considering only direct medical costs. Patients were assumed to either remain in their FC at 12 weeks until death or to deteriorate to FC IV and then receive INHI and palliative care until death. It was assumed that the initial choice of treatment would not affect survival, but instead would affect the proportion of time spent in FC IV. Deterioration was approximated by time to clinical worsening (TTCW), a composite measure of death or worsening of PAH leading to a change in treatment. Data on TTCW was taken from published literature and hospital databases containing over three years of data for patients treated in hospital for palliative care alone. For INHI, the TTCW was favourably assumed to equal that for bosentan. The utility associated with each FC taken from published literature; -no drug costs were estimated based on published literature and verified by a French expert clinician. Costs and benefits were discounted at 3% per annum. RESULTS: Bosentan dominated INHI, providing equivalent QALYs at a reduced cost. Bosentan also dominated NAT, providing an additional 0.38 QALYs whilst saving €8.142. Probabilistic sensitivity analyses estimated the probabilities of bosentan being cost-effective compared with NAT as 79% and 86% at cost per QALY thresholds of €30,000 and €50,000, respectively. CONCLUSIONS: Bosentan is a more cost-effective first-line therapy for patients with PAH FC III in Finland than either INHI or NAT.

ECONOMIC EVALUATION OF INHALED ILOPROST IN PRIMARY PULMONARY HYPERTENSION IN THE UK

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OBJECTIVES: Pulmonary Arterial Hypertension (PAH) is a devastating disease, which has a significant impact on patients’ quality of life and mortality. Both bosentan and inhaled iloprost (INHI) have demonstrated prolonged survival in long-term observational studies. We assessed the cost-effectiveness of adding bosentan, INHI or no active treatment (NAT) to palliative care, for patients with PAH of functional class (FC) III in Finland. METHODS: A cost-utility model simulated hypothetical patients with PAH, using a lifetime horizon and considering only direct medical costs. Patients were assumed to either remain in their FC at 12 weeks until death or to deteriorate to FC IV and then receive INHI and palliative care until death. It was assumed that the initial choice of treatment would not affect survival, but instead would affect the proportion of time spent in FC IV. Deterioration was approximated by time to clinical worsening (TTCW), a composite measure of death or worsening of PAH leading to a change in treatment. Data on TTCW was taken from published literature and hospital databases containing over three years of data for patients treated in hospital for palliative care alone. For INHI, the TTCW was favourably assumed to equal that for bosentan. The utility associated with each FC taken from published literature; -no drug costs were estimated based on published literature and verified by a French expert clinician. Costs and benefits were discounted at 3% per annum. RESULTS: Bosentan dominated INHI, providing equivalent QALYs at a reduced cost. Bosentan also dominated NAT, providing an additional 0.38 QALYs whilst saving €8.142. Probabilistic sensitivity analyses estimated the probabilities of bosentan being cost-effective compared with NAT as 79% and 86% at cost per QALY thresholds of €30,000 and €50,000, respectively. CONCLUSIONS: Bosentan is a more cost-effective first-line therapy for patients with PAH FC III in Finland than either INHI or NAT.
pharmacy. The total costs increase with age and level of general morbidity. The AHT
HEART FAILURE PATIENTS IN THE CZECH REPUBLIC
COST OF CORONARY ARTERY BYPASS GRAFT (CABG) IN ACUTE
0.001.
and total cost with the episodes number was 51.4% and 50.6% respectively,
costs although it was carried out in less than 5% patients.
failure is a life threatening disease which includes variable causes and complications.
acute heart failure (AHF) from health care payer perspective and to analyze the burden
Brno formed 9.2% total costs (median LOS 11 days; mean
0.006, Kruskal-Wallis test). 5 patients stayed in intensive care unit (ICU)
The median length-of-stay (LOS) in both centres was 25 days, mean cost
a strong from hospital to hospital. A total of eleven examinations, each of MRA and
occupation time of the operating room with MRA (average: 32 minutes) than with
proportionate investigation costs such as personnel and machine usage. The costs for
Angiography (DSA) when used to diagnose peripheral arterial occlusive disease (PAOD) from a German Hospital's perspective. METHODS: In this study we consid-
ered the direct cost attributable to the radiological department in a hospital, including proportionate investigation costs such as personnel and machine usage. The costs for
CONCLUSIONS: For patients with suspected PAOD angiography with contrast-enhanced MRA was found to be less costly than DSA. Our results align with cost-effectiveness analyses conducted in the UK and the USA that included in addition the outcomes of diagnosis-based therapeutic decisions. Increased use of contrast-
ANGIOGRAPHY (DSA) IN PATIENTS WITH PERIPHERAL ARTERIAL OCCLUSIVE DISEASE (PAOD) FROM A GERMAN HOSPITAL'S PERSPECTIVE. METHODS: In this study we consid-
tered the direct cost attributable to the radiological department in a hospital, including proportionate investigation costs such as personnel and machine usage. The costs for

**PCV123**

**COST OF ARTERIAL HYPERTENSION ACCORDING TO LEVELS OF MORBIDITY IN PRIMARY CARE SETTING**

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OBJECTIVES: To determine the health care cost and the labour incapacity of hyper-
tension according to different levels of morbidity in primary care centres (PC).

METHODS: Retrospective-multicentric design. Patients ≥ 40 year from seven teams of PC (year 2008) were included. Main measures: age, sex, cardiovascular co-
morbidity, Charlson index and general morbidity levels (Adjusted Clinical Groups;
low, moderate and high). It was established a model of direct costs (differenciating: fixed and variable [drugs, tests and referrals]) and indirect. Logistic regression analysis and ANCOVA was used for the model correction. Statistical significance: P < 0.05.

RESULTS: The prevalence of hypertension was 28.4% (95% confidence interval [CI]: 27.4–29.4%), mean age 67.5 (11.7) years and 56.7% of female. 71.3% of patients had one or more co-morbidity (95% CI: 71.3–75.1%). The average/unit of the total costs was €1312.1 (range, low co-morbidity: €633.1, moderately: €1297.2 and high: €2073.8, P < 0.001), Health care cost represented 98.2% of the whole and medication

**PCV124**

**COST OF CORONARY ARTERY BYPASS GRAFT (CABG) IN ACUTE HEART FAILURE PATIENTS IN THE CZECH REPUBLIC**

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OBJECTIVES: To assess direct in-hospital costs of CABG in patients hospitalized with
acute heart failure (AHF) from health care payer perspective and to analyze the burden
of CABG procedure in total in-hospital cost of AHF. METHODS: From total 1357 patients hospitalized with AHF in University Hospital Brno (UH) between 2003 and 2007, 4.6% patients were sent to undergo CABG procedure at the Cardio-surgical Centre. Direct cost include flat rate of admission, stay, medication and service) associated with congestive AHF hospitalisation and cost of consecutive CABG were evalu-
ted together as well as separately. (€/ 28.663).RESULTS: Forty-six patients with de novo AHF and 17 patients with acute decompensation of chronic heart failure were analysed (79.4% male; mean age 68.3 years; 38.7% after myocardial infarction). The median length-of-stay (LOS) in both centres was 25 days, mean cost €1953. Both LOS (median 23.3, 25.3 and 31 days) and costs (mean €8855; €10,915; €16,742) increased over the years 2005–2007 (statistical significant difference in in-hospital costs p = 0.006, Kruskal–Wallis test). 5 patients stayed in intensive care unit (ICU) with median LOS 20 days and mean cost €25,928, others spent median 10 days in ICU and 16 days in standard cardiology unit with mean cost €10,748. Stay in UH Brno formed 9.2% total costs (median LOS 11 days; mean €3,098, PCI performed in 7.9% patients); the remainder was concerned with CABG procedure (mean €10,855; LOS 15 days). Two patients (3.2%) died after CABG. CONCLUSIONS: Acute heart failure is a life threatening disease which includes variable causes and complications. One of the most costly procedures in AHF patients is revascularisation by means of percutaneous coronary intervention or CABG. CABG made 53.3% of total in-hospital costs although it was carried out in less than 5% patients.