clinical course of DVT may also be complicated by recurrent episodes of DVT, the development of chronic venous disease, or acute pulmonary embolism. Therefore, the aim of the study was to estimate the cost of VTE treatment in Turkey. METHODS: The study was undertaken from the Turkish health care payer perspective (MS). An Excel sheet was formed to determine the healthcare costs of VTE in treatment of VTE. Data were categorized and included diagnosis costs and treatment costs. Unit costs were taken from the Social Security Institution’s Health Implementation Guideline. RESULTS: According to the results of the study, costs of anticoagulants were €166,644, monitoring INR costs were €90,000, recurrent DVT costs were €1,979,412, recurrent FE costs were €30,849, non-IC major bleeding (GIS) costs were €1,482,49, Intraocular bleed costs were €3,868,87, and CEPH costs were €22,282.12. INR costs were €74,259,67 in Turkey. CONCLUSIONS: The study showed that VTE treatment poses a high treatment cost due to recurrence and OAC complications in the Turkish health care system.

PCV88 ECONOMIC BURDEN OF ACUTE MYOCARDIAL INFARCTION IN VIETNAM Nguyen TP1, Nguyen T2, Postma M3
1Groningen University, Groningen, The Netherlands, 2Thai Nguyen General Hospital, Thai Nguyen, Vietnam, 3Groningen University, Groningen, The Netherlands.
OBJECTIVES: Vietnam spends 6% of its GDP to health care. In context of insufficient evidence on quantifying the economic burden of cardiovascular disease in Vietnam, we conducted a study on the costs of Acute Myocardial Infarction (AMI). Costs were calculated from the perspective of the health care payer, including health care providers and patients. METHODS: Data was extracted from the database of a regional hospital in Vietnam. All patients with the single code I21 according to the International Classification of Disease 10 were included in the study. Costs were calculated in year 2013. Out-of-pockets payments was quantified as the net of health insurance (HI) reimbursement and actual payments. RESULTS: 89 patients > 18 years old were treated and had an inpatient stay due to acute myocardial infarction. A total of 5 cases required percutaneous coronary intervention and 55 cases requiring medicine only. Mean costs of AMI were US$ 2,503 (+/-3,377) per hospitalization. Costs per hospitalization were higher in the group requiring percutaneous coronary intervention than in the group requiring medicine only at US$9,960 (+/- 3,197) and US$365 (+/-403), respectively. Out-of-pocket payments were approximately 60% of these costs. Generally cost of AMI per hospitalization in Vietnam was higher than GDP per capita (US$ 1,900). CONCLUSIONS: Our results indicate that MI prevention is needed to reduce the burden of disease as well as to avoid catastrophic expenditure and impoverishment problems in Vietnam. Our results also comprise essential building blocks for important variables in a future cost-effectiveness modeling exercise on cardiovascular prevention.

PCV89 A COMPARISON OF TWO LOW-MOLECULAR-WEIGHT HEPARINS (LMWHs) IN TERMS OF COST PER PATIENT Flanelias L1, Mifarro C2, Restovic G1, Delgado M1, Rubio M1
1IMS Health, Barcelona, Spain, 2IMS Health, Madrid, Spain, 3Sanofi, Barcelona, Spain.
OBJECTIVES: to compare the total treatment duration cost per patient between the two most used low-molecular-weight heparins (LMWHs) in Spain for the prophylaxis of the venous thromboembolism disease (VTE) during the acute phase and at long term. METHODS: patients in prophylaxis were classified as moderate or high according to the risk of the surgery. Patients with high risk of VTE treatment were divided in two groups: 1) Oncologic or urologic surgery, 2) medical surgeries, and 3) medical patients (surgery is not performed by a surgical specialty but other specialists). Patients with DVT were divided into 10 kilogramme weight ranges as well as considering the distribution of the Spanish population in each range taken from the IBI registry. Treatment duration was obtained from clinical guidelines. Treatment duration and patient profile defined the strength and package size used to estimate the cost per patient in prophylaxis. Concerning DVT, only the most appropriate strengths for each weight range were considered. Costs are expressed in € of 2015 and calculated based on the retail price plus the value-added tax of each LMWH discounting the corresponding deduction according to Royal Decrees. RESULTS: administering enoxaparin instead of bemiparin represents a saving of €10 (5%), €29 (16%) and €10 (5%) per patient per total treatment duration with high risk surgery type 1, 2 and 3, respectively, and €45 (16%) per patient per total treatment duration with moderate risk. Average savings per patient per total treatment duration with VTE treatment was €29 (5%) 354€ (45%) in the acute phase and at long term, respectively. CONCLUSIONS: the cost of treating VTE or DVT is lower when administering enoxaparin instead of bemiparin. Therefore, the use of enoxaparin represents an economic benefit for the Spanish health system.

PCV90 THE COST OF ACUTE CARE HOSPITALIZATIONS ASSOCIATED WITH CHRONIC HEART FAILURE IN CANADA Fischer AA1, Liu N1, Borelli R1, Barbeau M2, Zaour N2
1IMS Brogan, Mississauga, ON, Canada, 2Novartis Pharmaceuticals Canada Inc., Dorval, QC, Canada.
OBJECTIVES: Chronic heart failure (CHF) affects more than 600,000 Canadians, resulting in thousands of hospitalizations and deaths each year. This study’s objective is to evaluate hospital costs of CHF patients with or without diabetes. METHODS: Hospital discharge abstracts recorded between 2009 and 2013 were extracted from the Canadian Institute for Health Information’s Discharge Abstract Database and National Ambulatory Care Reporting System Database. Patients with a diagnosis of acute coronary syndrome (ICD-10: I21/I22/I23) were retrieved from the database, with respectively 1,457, 1,194 and 30 of them for mortality. RESULTS: In-hospital mortality in STEMI was 9.3% (p < 0.001) and 8.4% in NSTEMI (ICD-9: 410–411.89) and unstable angina (UA, ICD-9: 411.4–411.84). PCI was identified with ICD-9 code 36.0. Comparisons were done using a Wilcoxon non-parametrical test for cost LOS and a Chi-square for mortality. RESULTS: 2,528 STEMI, 2,815 NSTEMI and 407 UA hospitalizations were retrieved from the database, with respectively 1,457, 1,194 and 30 of them treated invasively. PCI resulted in higher costs in STEMI (€9,342 vs. €8,165, p < 0.001) and UA (€9,186 vs. €4,714, p < 0.001) and in lower costs in NSTEMI (€8,483 vs. €9,483, p < 0.001). LOS of patients undergoing PCI was significantly lower in STEMI (6.2 vs. 9.7 days, p < 0.001) and NSTEMI (6.5 vs. 10.9, p < 0.001). In-hospital mortality in patients with PCI was lower in both STEMI (6.2% vs. 21.4%, p < 0.001) and NSTEMI (5.5% vs. 8.0%, p < 0.001). LOS (5.5 vs. 5.9 days) and mortality 0.7% vs. 3.2% were not significantly different in the STEMI and NSTEMI groups. CONCLUSIONS: The baseline characteristics of the different patients is limited, the findings of this retrospective study seem to support randomized clinical trials. Treatment with PCI significantly reduces in-hospital cost and the mortality in patients with a myocardial infarction, at a limited marginal cost.