artery disease. However, there is limited data on the subsequent hospitalizations and related direct health care costs among patients with pre-existing CKD undergoing treatment (PCI). This study was aimed to report the resource use and costs of cardiac-related hospital readmissions following PCI in patients with and without pre-existing CKD.

METHODS: Direct health care costs were estimated from 12,958 patients enrolled in the Melbourne Interventional Group (MIG) registry, who underwent PCI between April 2004 and October 2010. Only individual hospital data were included. Direct medical costs are those directly attributable to the illness under study and include costs of inpatient care, outpatient care, physician services, and prescription drugs. Indirect costs such as lost productivity are not included. All costs are expressed in 2010 Australian dollars ($AUD). The population was divided into two groups: 1) those with pre-existing CKD (stage ≥3) and 2) those without CKD. Medical costs included hospitalization, emergency room visits, in-patient consultations, and other medical services. Costs were calculated by multiplying the number of visits or days spent in healthcare facilities by specific rate charges. The cumulative costs of all patients were compared, and the costs associated with CKD were calculated.

RESULTS: The mean follow-up time was 335 days following the surgery. This retrospective cohort study compared medical costs between patients with and without pre-existing CKD.