initial diagnostic test were identified from a multicenter database using complete facility, physician and pharmacy data from two large health care plans from 2003–05. 1-year downstream CAD-related episodes of care were examined for patients after initial MDCT or MPI. Costs were further sub-classified by utilization of high-cost resources, including cardiac catheterization, percutaneous transluminal coronary angioplasty (PTCA), and coronary artery bypass surgery (CABG). RESULTS: A total of 18,489 patients underwent either MDCT (n = 638) or MPS (n = 17,851) testing during the study period. While costs per CAD-related episodes were similar between MDCT and MPS groups ($5,878 vs. $6,079, p = 0.20), patients undergoing MDCT had fewer total numbers of CAD-related episodes of care (4.246 vs. 5.065, p < .0001). High-cost CAD test utilization was also lower for MDCT patients compared to MPI patients for cardiac catheterization (15.673 vs. 29.132, p < 0.0001), PTCA (0.940 vs. 2.341, p = 0.020), and CABG (2.351 vs. 5.274, p = 0.001). After adjustment for age, gender, baseline cardiovascular risk, and baseline health status, one-year total CAD-related episodes of care costs for MDCT were 16.4% lower than MPS, by an average of $800.

OBJECTIVES: To estimate the cost of BMS and DES placement in coronary artery disease patients and to determine the cost-effectiveness of DES versus BMS in the Chinese public hospital setting. Further cost-effectiveness analysis will be conducted to evaluate the differences between DES and BMS.

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CLINICAL AND ECONOMIC IMPACT OF DRUG-ELUTING STENT AND BARE METAL STENT IN HONG KONG—A SINGLE CETRE “REAL WORLD” EXPERIENCE: AN INTERIM ANALYSIS
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OBJECTIVES: We aimed to evaluate the clinical outcome of BMS and DES placement in coronary artery disease patients and estimate the cost of BMS and DES placement in a Chinese population. METHODS: It was a retrospective cross-sectional study. We included all patients who underwent PCI with stent placement of either DES or BMS in a tertiary public hospital in Hong Kong over 4-month period. Patients were followed up for the occurrence of MACE within 12 months of the index stent placement. MACE was defined as cardiac death, non-fatal myocardial infarction and target lesion revascularization. Direct medical costs were estimated based on the procedural cost, hospitalization, medications, cardiac follow-up and repeated interventions taken. RESULTS: This interim analysis included 184 patients. Twelve-month MACE rate was 12.2% in BMS versus 3.4% in DES (p = 0.042). Rate of cardiac death was 3.7% in BMS versus 0% in DES group (p = 0.110). The mean 12-month cost per patient after index PCI was USD 8827.6 ± 5634.0 (median = 7268.2) in DES and USD 7222.4 ± 4538.1 (median = 6170.5) in BMS. On average, DES costs USD 1605.1 more than BMS per patient. CONCLUSION: Routine usage of DES is more costly than BMS that may discourage the use of DES in our public hospital setting. This may be explained by the less than expected difference in 12-month MACE between DES and BMS in our population and the lower hospitalization costs in Hong Kong. Further cost-effectiveness analysis will be conducted to evaluate the differences between DES and BMS.