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COST OF TREATMENT OF HYPERCHOLESTEROLAEMIA TO NHF GOALS IN AUSTRALIA
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OBJECTIVE: To estimate the comparative cost-effectiveness of atorvastatin and simvastatin. METHODS: A randomized clinical trial set in general practice. Effectiveness was measured by percentage reduction in total cholesterol and percentage of patients achieving NHF targets. The costs calculated in the study were hospital admissions, emergency room/clinic visits, visits to GPs and specialists, tests/investigations, treatment of adverse events and drug costs. RESULTS: Of the 691 patients in the atorvastatin arm, 682 used health care resources. Of the 337 patients in the simvastatin arm, 332 used health care resources. The monthly drug costs with atorvastatin was $48.30 for 10mg, $66.93 for 20mg, with simvastatin at $42.06 for 10 mg, $58.12 for 20mg. The average cost of health care for atorvastatin and simvastatin was $460.48 and $490.11 respectively (p = 0.47). Adverse events accounted for 60% of all health care costs in the atorvastatin group, 77% in the simvastatin group. The weighted average monthly drug costs (WAMDC) after 6 weeks of treatment were $48.30 for atorvastatin and $42.06 for simvastatin. 38% of patients reached NHF target cholesterol levels on atorvastatin, 25.5% on simvastatin. The cost per responder was $1.27 with atorvastatin, $1.63 with simvastatin. After 12 weeks of treatment the WAMDC was $59.53 for atorvastatin, $53.77 for simvastatin with 47.5% and 33.8% response rates, respectively. The incremental cost-effectiveness of an extra patient achieving target on atorvastatin was $0.50 at 6 weeks, $0.42 at 12 weeks, $0.26 at 18 weeks and $0.51 at 24 weeks. CONCLUSION: Atorvastatin achieved a greater percentage reduction in total cholesterol per mg than simvastatin, and was equally well tolerated. While drug costs for atorvastatin were slightly higher, overall health care costs were lower than for simvastatin. Atorvastatin was more cost-effective than simvastatin in achieving NHF targets. The incremental cost-effectiveness of atorvastatin suggests additional patients can achieve NHF targets relatively inexpensively.

PCV39
COST-EFFECTIVENESS OF LIPID LOWERING INTERVENTIONS IN A NATIVE AMERICAN CARDIOVASCULAR RISK REDUCTION PROGRAM
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OBJECTIVES: To determine the cost-effectiveness (CE) of managing patient low density lipoprotein-cholesterol (LDL-C) levels with exercise plus nutritional therapy and exercise plus nutritional plus pharmacotherapy from the Indian Health Service perspective. METHODS: A retrospective database analysis was performed on data collected from a pharmacist managed Cardiovascular Risk Reduction Program (CVCRRP) from March 1997 through October 1999. Patients received exercise plus nutritional therapy (Group 1) or exercise plus nutritional plus pharmacotherapy (Group 2). Effectiveness measures included unit and percent LDL-C reduction from initial to last recorded visit. Costs (fixed plus variable) and reimbursements were determined in terms of 1999 dollar values through clinic staff interviews and billing records.
Socioeconomic Relevance of Treatment of Chronic Heart Failure Stage NYHA II with Crataegus Extract WS 1442—One-Year-Results of a Prospective Pharmacoeconomic Study

**OBJECTIVES:** To evaluate the pharmacoeconomic properties of crataegus treatment compared to any other treatment option of CHF at stage NYHA II, a prospective 3-year observational study has been conducted since summer 1999. A cost-utility-analysis will be performed to investigate, if crataegus treatment avoids rapid deterioration with higher costs and lower LDL-C outcomes. Group 2 interventions also resulted in more favorable average CE ratios compared to Group 1. Study results could be used to develop similar cardiovascular risk reduction programs, expanding the clinical role of the pharmacist and improving patient outcomes.

**RESULTS:** Net cost-per-patient in Group 1 (n = 40) was $1,204; in Group 2 (n = 32) was $1,432. Mean LDL-C reduction was 12.67 mg/dl (Group 1) and 42.03 mg/dl (Group 2). Mean percent LDL-C reduction was 8.95% (Group 1) and 50.70% (Group 2). Average CE ratios were $95.01 (unit LDL-C reduction) and $134.50 (percent LDL-C reduction) for Group 2 versus Group 1 was $7.77 (unit LDL-C reduction) and $11.82 (percent LDL-C reduction). The obtained CE ratios were robust to sensitivity analysis parameters. **CONCLUSIONS:** The CVCRRP showed positive lipid management results for enrolled patients. Group 2 (those including pharmacotherapy) interventions were associated with higher costs and better LDL-C outcomes. Group 2 interventions also resulted in more favorable average CE ratios compared to Group 1. Study results could be used to develop similar cardiovascular risk reduction programs, expanding the clinical role of the pharmacist and improving patient outcomes.