COST-EFFECTIVENESS OF PLANNED CAESAREAN SECTION VERSUS PLANNED VAGINAL DELIVERY IN BREECH-PRESENTATION PREGNANCIES AT TERM

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OBJECTIVES: To examine the cost-effectiveness of planned caesarean section versus planned vaginal delivery in breech-presentation pregnancies at term. METHODS: An incremental cost-effectiveness analysis was performed using a Markov model for a hypothetical cohort of 25-year old pregnant women with a live singleton fetus in a frank or complete breech presentation at term. Caesarean section was compared with vaginal delivery from a societal perspective. The model operated over 25 years in 3-year cycles. The model integrated clinical and cost data from peer-reviewed studies and utilities to estimate cumulative quality-adjusted life years (QALYs) and costs for both the mother and infant. Effects and costs were discounted at 4%. Probabilistic sensitivity analyses were performed to determine key parameter uncertainty. RESULTS: If only maternal morbidity was taken into account, caesarean section was more costly and less effective (incremental cost-effectiveness ratio (ICER) –€54,000 per QALY), thus vaginal delivery was the dominated strategy. If only neonatal morbidity and mortality was considered, caesarean section was less costly and more effective (ICER –€2120 per QALY). However, if outcomes for both mother and child were considered, caesarean section was more costly but more effective (ICER €1275 per QALY). CONCLUSIONS: Caesarean section resulted to be cost-effective compared to vaginal delivery in breech presentation at term, if both maternal and neonatal outcomes were considered. If only maternal condition is considered, vaginal delivery appeared to be the best strategy.

COST-EFFECTIVENESS OF LEVONORGESTREL-RELEASING INTRAUTERINE SYSTEM (LNG-IUS) FOR THE TREATMENT OF DYSFUNCTIONAL UTERINE BLEEDING (DUB) IN SPAIN

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OBJECTIVES: To compare the cost-effectiveness of different therapies for the treatment of dysfunctional uterine bleeding (DUB) in Spain. METHODS: A decision-analytic model was built to estimate the clinical and economic consequences of initiating treatment for DUB with either levonorgestrel intrauterine system (LNG-IUS), combined oral contraceptives (COC), progestogens (PROG) or tranexamic acid (TRAX) and switching to COC (after failure with LNG-IUS or PROG) or to LNG-IUS (after failure of COC) or to a combination of both (50% to LNG-IUS and 50% to COC after failure with TRAX), whilst surgery (hysterectomy and endometrial resection) was assumed to be used as third line therapy in the base case. Model probabilities were obtained from published systematic reviews and treatment pathways after initial failure and/or presence of adverse events (including pregnancy in women requiring contraception) where derived from expert opinion. Local data on health resource use and costs were used and validated by clinical experts. Effectiveness was measured as symptom-free months (SFM) and modelled up to 5 years. The analyses take the perspective of the National Health System, so excluding all costs not supported by the public system (i.e. COC acquisition costs).

RESULTS: Preliminary results show that the higher efficacy of LNG-IUS translates to a gain of 0.3–3.42 SFM at 5 years. Whilst LNG-IUS shows a short-term higher cost than the other options, posterior savings derived from a lower surgery rate, due to a better control of DUB, yields to cost savings respect to PROG, COC and TRAX of €158.6, €179.6 and €270.7, respectively. Furthermore, if surgery is assumed to be the only second line option after first line failures, cost savings with LNG-IUS could be more than €400 after 5 years. CONCLUSIONS: Preliminary results of this study indicate that LNG-IUS is a dominant option with respect to COC, PROG or TRAX, with lower costs and higher effectiveness than these therapies.

THE COST EFFECTIVENESS OF SCHEDULED MAINTENANCE TREATMENT WITH INFLIXIMAB AMONG PAEDIATRIC PATIENTS WITH CROHN’S DISEASE IN SCOTLAND

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Infliximab has recently been approved for use in paediatric patients with severe active Crohn’s disease (CD) and is the only biologic licensed in this patient population. OBJECTIVES: To estimate the cost effectiveness of scheduled maintenance treatment with infliximab among children suffering from severe active CD in Scotland. METHODS: A Markov model was constructed to simulate the progression of a hypothetical cohort of CD children through predefined health states on scheduled maintenance treatment with infliximab (5 mg/kg) based on Targan, ACCENT I and REACH trials. The health states used in the model were remission, therapy (infl.imab) responsive active disease, non-responding active disease, surgery, post surgery remission and post surgery complications. Standard care, comprising immunomodulators and/or corticosteroids was used as a comparator. The primary outcome was quality adjusted life years (QALYs) estimated using EQ-5D from a European CD population. An average patient weight of 40 kg was used to estimate the dose of infliximab. The costs and outcomes were discounted at 3.5% over a period of 5 years. Stochastic sensitivity analyses were performed by varying the infliximab efficacy estimates, costs and utilities. RESULTS: The incremental cost effectiveness ratio (ICER) for scheduled maintenance treatment with infliximab was £12,483 for severe active CD children in Scotland. The sensitivity analyses revealed the analysis time horizon and efficacy estimates to be the most influential parameters with ICERs ranging from £5,348–£25,950. CONCLUSIONS: Scheduled maintenance treatment with infliximab (5 mg/kg) is a cost effective treatment option for children suffering from severe active CD under an 8-week scheduled maintenance programme in Scotland.

COST OF INSOMNIA IN PATIENTS OVER 54 YEARS IN SWEDEN

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OBJECTIVES: To summarise the existing evidence on the cost of primary insomnia in persons aged 55 and above in Sweden and to generate an estimate of its total societal cost based on national statistics and other public sources. METHODS: We performed a top-down cost of illness analysis based on the Living Conditions Survey and national registry data from the Swedish Social Insurance Board (Forsakringskassan), the National Board of Health and Welfare (Socialstyrelsen) and the