METHODS: Data for the cost-effectiveness analyses were obtained from a case control study and two randomized controlled trials comparing the surgical outcomes related to temperature control using the Arctic Sun versus the current surgical warming methods. The incremental cost-effectiveness per hypothermia case avoided was calculated by measuring the extra costs to the hospital for achieving an extra unit of effectiveness by using the Arctic Sun.

RESULTS: Using the definition of hypothermia as a temperature less than 36°C, there were three cases (5%) of post-operative hypothermia out of 58 for patients warmed using the Arctic Sun method. Using the standard of care, 23 out of 48 patients (48%) were hypothermic. The treatment costs for preventing post-operative hypothermia includes $60 in variable costs for the standard of care. Costs for using the Arctic Sun for preventing post-operative hypothermia included $350 in variable costs and $9.85 in allocated annual fixed costs (total treatment cost—$359.85 per patient). Subtracting the relative cost to treat 100 patients using the standard of care ($6,000) from the relative cost of warming 100 patients using the Arctic Sun ($35,985) yielded an incremental cost effectiveness of $697.33 per post-operative hypothermia case avoided by using the Arctic Sun.

CONCLUSION: Use of the Arctic Sun™ is both effective and cost-effective in preventing post-operative hypothermia during OPCAB procedures.

COST OF ILLNESS AND RESOURCE UTILIZATION FOR PATIENTS SUFFERING MYOCARDIAL INFARCTION, WITH AND WITHOUT DEPRESSION
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Approximately 1.5 million individuals experience a myocardial infarction (MI) each year in the United States. Of these, 20% develop major depression (MDD) and are at increased risk of re-infarction, overall morbidity and mortality.

OBJECTIVE: The objective of this study was to compare the health care costs and resource utilization for patients diagnosed with MI + MDD with patients with MI only, MDD only and a control group having neither condition.

METHODS: Claims data for all patients at least 40 years of age from a large HMO in the Southeast US were analyzed retrospectively. Patients were selected for study if they had an incident event of MI, MDD, or MI+MDD during a one-year recruitment period. Age and sex matched patients having neither MI nor MDD during the recruitment period served as the control group. Patients were followed for two years from their dates of recruitment. Patients were included in the MI+MDD group only if they had at least six months of data for analysis. Only patients with drug charges were included for final evaluation.

RESULTS: Compared with $6,877 for patients in the control group (n = 436), mean total costs were statistically different for each group, including $13,982 for MDD patients (n = 296), $35,589 for MI patients (n = 98), and $37,835 for MI+MDD patients (n = 53). Significant differences between the groups were found for the number of hospitalizations, length of hospital stay, outpatient visits, types of prescribed medication, and number of filled prescriptions. Other significant differences between groups included their need for therapeutic drug assays, particularly digoxin, and cardiovascular laboratory procedures, particularly the use of devices to monitor for arrhythmia.

CONCLUSION: The cost of illness and resource utilization for patients who had MI+MDD are much greater than patients having MI or MDD alone. Early recognition of patients with MI+MDD is warranted.

QUALITY OF LIFE QUESTIONNAIRES VALIDATION IN ESSENTIAL HYPERTENSIVES FROM AN ECONOMICALLY DISADVANTAGED COMMUNITY
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Validity and clinical relevance of the quality of life (QL) measures developed in Western civilization societies may quite differ from those in countries experiencing socioeconomic hardships.

OBJECTIVES: We aimed to validate the set of QL questionnaires in essential hypertensives (EH) from Belarusian population.

METHODS: Internationally recognized, self-administered, culturally non-specific, and professionally translated into Russian questionnaires were used: the General Well-Being Adjustment Scale (GWBAS), Duke Health Profile (DHP), Giessen Somatic Complaints Questionnaire (GSCQ). The QL assessment was carried out in 212 EH without concomitant diseases (100 males; mean age 48.5 ± 12.3 years; BMI 30.3 ± 12.3kg/m²; SBP 168.4 ± 26.6 mmHg, DBP 105.4 ± 13.3 mmHg) and in 57 age-, gender- and BMI-matched healthy subjects.

RESULTS: Cronbach’s coefficient alpha more than 0.7 was determined for GWBAS subscales (range 0.67–0.84; mean 0.77) excepting “self-control”, for GSCQ (range 0.54–0.86; mean 0.74) excepting “gastric complains”, but not for DHP (range 0.47–0.68; mean 0.57). Correlation matrix revealed significant and the highest Spearmen correlation coefficients of GWBAS subscales scores with corresponding DHP and GSCQ subscales scores, excepting GWBAS subscale “vitality”. The total well-being