age at diagnosis is 7.04 (range 2–14). 22.7% of the ADHD-children exhibit a score below 15 on the IOWA-CRS, 54.06% have a score between 15 and 22 and 22.7% suffers from a severe form of ADHD with a score above 22 (maximum 30). The resource use of an ADHD-child is significantly higher compared to their siblings. Using McNemar tests we found that ADHD-children are significantly more likely to have emergency department visits (20.4% vs. 6.8%) and specialist visits (22% vs. 3.2%). The severity of the disorder is positively related to medication and specialist use (Wilcoxon Signed Rank Test). Parents stay significantly more often home from work for their ADHD-child (10.6% vs 2.4%) and significantly more children with ADHD miss a year at school (17.2% vs. 4.3%) or go to a special school for children with learning disabilities (10% vs. 0.9%). CONCLUSION: Childhood ADHD results in significantly higher use of health care and adversely affects school attainments and parents’ productivity. This puts a heavy burden on the family. Nevertheless we have to take into consideration we have used a non-random sample and that we used siblings as a comparator group.

**CARdiovascular DISEASES II**

**SHORT AND LONG-TERM COST-EFFECTIVENESS ANALYSIS OF CLOPIDOGREL IN PATIENTS WITH ACUTE CORONARY SYNDROME WITHOUT ST-SEGMENT ELEVATION (ACS) IN SCANDINAVIAN COUNTRIES**

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**OBJECTIVE:** The CURE trial demonstrated the superior efficacy of clopidogrel compared to placebo, both groups receiving standard therapy including ASA in preventing myocardial infarctions, strokes, and cardiovascular deaths in patients with ACS. The purpose of this analysis was to evaluate short and long term cost-effectiveness of clopidogrel in 4 Scandinavian countries: Denmark, Finland, Norway and Sweden. METHODS: A within trial analysis was performed based on data collected alongside the clinical trial (hospitalizations, procedures, comedication, and study drugs). Hospitalization costs were evaluated through a Diagnosis Related Group approach. Cost-effectiveness was expressed as the cost per event avoided. A long term model using Swedish epidemiological data (national registry) was also performed to capture the long term benefits of clopidogrel. A Markov model with six states (at risk, first year with stroke, following years with stroke, first year with new MI, following years with new MI and death) was used. Cost-effectiveness was expressed as the cost per life year gained (LYG). Costs used were for the 2001 year. Both costs and benefits were discounted at 3%. RESULTS: Occurrence of the composite outcome was significantly lower in the clopidogrel arm (11.14% versus 13.15%). Patients in the clopidogrel arm have on average higher costs than patients treated with ASA alone: the net incremental cost ranges from €289 to €488. This leads to a cost per event avoided ranging from €13,391 to €24,700. The long term model predicts an incremental survival of 0.117 years for an incremental direct medical cost ranging from €64 to €488 per patient. The cost per LYG ranges from €549 to €4003. When indirect costs are included this ratio is €2181 in Finland and clopidogrel is cost saving in other countries. CONCLUSION: Both short and long term analyses conclude that clopidogrel is very cost effective in the treatment of patients with ACS.

**AN ECONOMIC EVALUATION OF CLOPIDOGREL VS. ASPIRIN IN SECONDARY PREVENTION OF ISCHEMIC EVENTS IN HIGH RISK ATEROTHROMBOTIC PATIENTS**

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**OBJECTIVES:** To determine the incremental cost per life year saved (ICLYS) of clopidogrel versus ASA in secondary prevention of ischemic stroke (IS), myocardial infarction (MI), or vascular death (VD) in 2 high risk subgroups of the CAPRIE trial (patients with prior IS or MI to index event, and atherothrombotic patients treated for hypercholesterolemia and/or with diabetes) in Belgium. METHODS: A Markov model designed with 7 clinical states calculated ICLYS as the cost needed to achieve an extra life year with clopidogrel compared to ASA. The model combined rates of clinical outcomes calculated from the CAPRIE database and survival data derived from the Saskatchewan database. The costing of events, including acute care and follow-up, was performed using official data (DRG systems), tariffs and/or charges (physicians fees, examinations, lab tests), divided in acute costs and costs per subsequent 6 month follow-up periods. The economic analysis was performed from the health care system perspective using only direct medical costs for 2-year treatment. A discount rate of 3% was applied to costs and lifetime effects. RESULTS: In first subgroup (prior MI or IS), 27 additional atherothrombotic events (14 MI, 12 IS, 1 VD) were avoided per 1000 patients treated with clopidogrel versus ASA with a gain in survival of 119 years. In second subgroup (hypercholesterolemia and/or diabetes), 28 additional atherothrombotic events (14 MI, 8 IS, 6 VD) were avoided with a gain in survival of 130 years per 1000 patients. The incremental cost of the clopidogrel arm compared to ASA was €702 in first group and €771 in second group. The ICLYS was very similar in the 2 subgroups: €5900 and €5930 respectively. Results were robust under a wide variation...
of key parameters. CONCLUSION: Clopidogrel as an alternative to ASA is a cost-effective strategy in secondary prevention of ischemic events for high-risk atherothrombotic patients.

**OBJECTIVES:** Fondaparinux, a new synthetic selective factor XA inhibitor was recently introduced into the market. This may have widespread implications for Health care providers that are expected to vary across countries. We evaluated the cost-effectiveness of fondaparinux relative to enoxaparin up to 5-years in the prophylaxis of venous thromboembolism (VTE) following major orthopaedic surgery and compared the results across countries. We developed an economic model and assessed the effect of fondaparinux relative to enoxaparin, both given for 7 days, on patient clinical outcomes and costs in Belgium, Italy, The Netherlands, Spain, UK. The perspective was that of the third party payer. Outcomes are symptomatic deep vein thrombosis, pulmonary embolism, recurrences, post-thrombotic syndrome and death. Data on the incidence of VTE events were derived from four randomised clinical trials comparing enoxaparin with fondaparinux, and from a review of the literature. Resource consequences and costs were estimated locally using national or hospital databases, clinician opinion, literature... and validated by experts. RESULTS: In a hypothetical cohort of 1000 patients, weighted to reflect the proportion of patients undergoing hip or knee replacement, or hip fracture surgery in each country, the expected number of VTE events averted with fondaparinux ranged from 17 to 20 and the number of VTE-related deaths averted is 2 to 3. Results were consistent across countries: break-even point in costs was achieved at day 90 or even earlier. The expected savings with fondaparinux at 5 years would range between €26,000 and €38,000. These findings were found to be robust to wide variations in key assumptions in the model. CONCLUSIONS: Compared with current practice in Europe, fondaparinux is a cost-effective and dominant strategy in the prophylaxis of venous thromboembolism following major orthopaedic surgery in all countries investigated.

**COST-EFFECTIVENESS OF A NEW ANTITHROMBOTIC AGENT: A COMPARISON ACROSS COUNTRIES OF THROMBOPROPHYLAXIS WITH FONDAPARINUX FOLLOWING MAJOR ORTHOPAEDIC SURGERY**

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**OBJECTIVES:** Fondaparinux, a new synthetic selective factor XA inhibitor was recently introduced into the market. This may have widespread implications for Health care providers that are expected to vary across countries. We evaluated the cost-effectiveness of fondaparinux relative to enoxaparin up to 5-years in the prophylaxis of venous thromboembolism (VTE) following major orthopaedic surgery and compared the results across countries. We developed an economic model and assessed the effect of fondaparinux relative to enoxaparin, both given for 7 days, on patient clinical outcomes and costs in Belgium, Italy, The Netherlands, Spain, UK. The perspective was that of the third party payer. Outcomes are symptomatic deep vein thrombosis, pulmonary embolism, recurrences, post-thrombotic syndrome and death. Data on the incidence of VTE events were derived from four randomised clinical trials comparing enoxaparin with fondaparinux, and from a review of the literature. Resource consequences and costs were estimated locally using national or hospital databases, clinician opinion, literature... and validated by experts. RESULTS: In a hypothetical cohort of 1000 patients, weighted to reflect the proportion of patients undergoing hip or knee replacement, or hip fracture surgery in each country, the expected number of VTE events averted with fondaparinux ranged from 17 to 20 and the number of VTE-related deaths averted is 2 to 3. Results were consistent across countries: break-even point in costs was achieved at day 90 or even earlier. The expected savings with fondaparinux at 5 years would range between €26,000 and €38,000. These findings were found to be robust to wide variations in key assumptions in the model. CONCLUSIONS: Compared with current practice in Europe, fondaparinux is a cost-effective and dominant strategy in the prophylaxis of venous thromboembolism following major orthopaedic surgery in all countries investigated.

**CLINICAL OUTCOMES AND COSTS OF DRUG ELUTING STENTS IN THE CARDIAC CATHETERIZATION LAB**

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Drug-eluting stents (DES) have been shown to reduce the risk of restenosis post coronary intervention compared with conventional stents (CS). However, the cost of DES is significantly higher than CS. OBJECTIVE: To evaluate the utilization of DES along with clinical indications, outcomes and cost impact within the cardiac catheterization lab. METHODS: Demographic, clinical and angiographic data were collected retrospectively on all patients who underwent DES implantation between October 15, 2002 and April 15, 2003. Cost data, specifically stent costs, were collected concurrently. RESULTS: A cohort of 46 patients was treated with DES, involving 52 vessels and utilizing 62 stents (56 Cypher, 6 Taxus). Indications for coronary intervention were stable angina (67.2%) and ACS/post MI (32.6%). Indications for DES use included clinical reasons such as diabetes mellitus (15.2%), prior bypass surgery (19.6%) and renal insufficiency (8.7%). Angiographic indications included: stenosis length >18 mm (43.4%), vessel diameter <2.5 mm (32.6%), patients with multivessel disease (21.7%) and instent restenosis (8.7%). Short-term clinical complications included death but no strokes or myocardial infarctions. The procedural success was 95.8% (44/46), and the clinical success was 92.5% (43/46). The average number of DES per patient was 1.35. During the same time period, 351 patients were treated with CS, utilizing 522 stents. The average number of stents per patient was 1.48. The total hospital-incurred DES cost was $227,700 for an average stent cost $4945.65 per patient. In the CS group the total cost for stents was $496,050 for an average cost of $1413.25 per patient. The average number of stents per patient was 1.48. The total hospital-incurred DES cost was $227,700 for an average stent cost $4945.65 per patient. In the CS group the total cost for stents was $496,050 for an average cost of $1413.25 per patient. The average stent cost per patient was 3.5 times higher in the DES group than with CS. CONCLUSIONS: 1) Indications for DES use are consistent with individuals at higher risk for restenosis; 2) the procedural costs for treating these individuals are significantly greater; and 3) full 6 month outcomes and cost data will be available for presentation.

**ADHERENCE/COMPLIANCE**

**LOWER PERSISTENCE WITH ANTIHYPERTENSIVE DRUGS AMONG WOMEN COMPARED TO MEN**

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