Microsoft Excel. The model compares the cost-effectiveness of standard diagnostics with the one of ILR-enhanced diagnostic pathways. Number of positive diagnoses was used as the outcome measure. The number of diagnostic tests per patient and the yield of each test were found in published clinical literature. Cost data were taken from Dutch national sources. Sensitivity analyses were conducted using Monte Carlo Simulation. **RESULTS:** Literature and sensitivity analyses clearly show that the ILR-based pathway has a significantly higher capacity of providing a correct diagnosis (33.7% vs. 4.1%) within the same timeframe. The cost per diagnosis in the ILR-based pathway was slightly higher than the cost per diagnosis of more conventional care (approximately €1200 more needed per diagnosis with ILRs). **CONCLUSIONS:** ILRs can be considered an established, safe and efficient addition to syncope diagnostics. They provide physicians with excellent diagnostic yield, enabling timely and correct treatment of patients whose condition could remain undiagnosed. Cost per diagnosis demonstrates the cost-effectiveness of their use. Potentially, ILRs can also reduce time-to-diagnosis and operational expenditure of the hospital. Should that be the case, ILRs can be even more cost-effective while enabling more patients to get life-saving treatment faster.

PCV49

COST-EFFECTIVENESS OF ATORVASTATIN 80 MG VS GENERIC SIMVASTATIN 20 TO 40 MG IN SECONDARY PREVENTION IN SPAIN

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OBJECTIVES: The IDEAL trial (Incremental Decrease in End Points through Aggressive Lipid Lowering) was an open label, blinded endpoint evaluation of 8888 patients with history of acute myocardial infarction (MI) who were randomized to atorvastatin 80 mg or simvastatin 20–40 mg. The median follow-up was 4.8 years. Major coronary events (coronary death, hospitalization for MI, or resuscitated cardiac arrest) were reduced by 11%, (hazard ratio [HR], 0.89; 95% confidence interval [CI], 0.78, 1.01; P = 0.07). There was a 16% relative risk reduction in all cardiovascular events (HR 0.84, 95% CI: 0.76 to 0.91). The objective of the study was to asses the cost-effectiveness ratio of atorvastatin 80 mg versus simvastatin 20–40 mg among patients with history of coronary heart disease (CHD) in Spain taking into account all CV events. **METHODS:** A within trial pharmacoeconomic analysis was developed to estimate cost per event avoided. Direct (hospitalization, drugs) and indirect costs (lost production due to work absence) were included in the model. To estimate the cost of these hospitalizations, drug reimbursement group (DRG) was used. Effectiveness was estimated as the number of events in both arms. **RESULTS:** After 4.8 years, treatment with intensive atorvastatin could avoid 1 in 6 CV events compared with moderate simvastatin therapy among patients with CHD. Despite atorvastatin having a higher drug cost, this was offset by lower cost of reduced hospitalizations and work days lost for patients receiving atorvastatin treatment. Using Spanish costs the incremental cost for atorvastatin to avoid an event was €15,168. **CONCLUSIONS:** In a cohort of 8888 Spanish patients with CHD one cardiovascular event could be prevented for cost of €1520 euros/patient over 4.8 years. Based on these results, it appears that even in a low cost generic market, high dose atorvastatin is a good option compared to standard therapy with simvastatin.

PCV50

COST-EFFECTIVENESS OF RULING OUT DEEP VENOUS THROMBOSIS IN PRIMARY CARE VERSUS CARE AS USUAL

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OBJECTIVES: The timely diagnosis of deep venous thrombosis (DVT) is critical because this disorder can be life threatening. However, referring all patients suspected of DVT for ultrasound (US) testing is inefficient since 80 to 90% of those referred have no DVT. Therefore, we investigated the cost-effectiveness of a diagnostic strategy based on a point of care d-dimer test combined with a clinical decision rule that was documented to be safe in primary care (AMUSE study). **METHODS:** A model based cost-effectiveness analysis was conducted in conjunction with a recent multi centre prospective diagnostic study (AMUSE, N = 1002). A Markov model with a five year time horizon was used to compare the AMUSE strategy to two hospital based strategies: ultrasound for all and a hospital decision rule. Probabilities were derived from AMUSE and the literature. Societal costs and health state utilities were used. One way and probabilistic sensitivity analyses were conducted. Cost-effectiveness acceptability curves were constructed. **RESULTS:** The AMUSE strategy has both slightly lower costs and less quality adjusted life years (QALYs) than both hospital based strategies. The ultrasound for all strategy has the highest costs and QALYs, but is not cost-effective as compared the hospital decision rule strategy. The AMUSE strategy compared to the hospital decision rule strategy resulted in a mean saving of €138, and a mean QALY loss of 0.002. The incremental cost-effectiveness ratio is €56,436 per QALY lost. The cost-effectiveness acceptability curves show that the AMUSE strategy has the highest probability of being cost-effective, even exceeding ceiling ratios of €80,000 per QALY. **CONCLUSIONS:** The AMUSE strategy to exclude DVT in primary care is not only safe, but also has the highest probability of being cost-effective as compared to hospital based strategies to diagnose DVT.

PCV51

SINGLE PILL AMLODIPINE/ATORVASTATIN IS COST-EFFECTIVE FOR THE PRIMARY PREVENTION OF CARDIOVASCULAR DISEASE IN KOREA

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OBJECTIVES: Hypertension and dyslipidemia are highly prevalent, often concurrent and act independently, as well as together, to increase the risk of cardiovascular disease (CVD). This study sought to investigate the cost-effectiveness of a single-pill combination of amlodipine/atorvastatin (SPAA) for the primary prevention of CVD (comprising coronary heart disease and ischemic stroke) in Korea. **METHODS:** A Markov model was developed with four health states: 'Alive without CVD', 'Alive with CVD', 'Dead from CVD' and 'Dead from non-CVD causes', The model cohort used comprised 171 Korean adults aged ≥55 years from the 2005 Korea National Health and Nutritional Examination Survey (KNHANES) who were CVD-free but met current Korean criteria for treatment with SPAA. Follow-up was simulated for 40 years. Cardiovascular risk was estimated for each subject individually using a published, multivariable, Asian-specific equation. With subsequent cycles, the cardiovascular risk profile of each subject was updated. Data regarding the