showed a strong trend for less CV-events (p = 0.098). Cost-effectiveness of screening for elevated albuminuria was €16,559/LYG (from €7,030 to €24,125 in sensitivity analysis). Stochastic analysis indicated that the probability of cost-effectiveness below the suggested Dutch threshold for cost-effectiveness of €20,000 per LYG is 60% in the baseline analysis, increasing to 91% if only those subjects are treated with foscarnet showcasing a UAE >50mg/24hr. Also, limiting screening to only those aged greater or equal than 50; improved cost-effectiveness considerably. CONCLUSION: Primary prevention by screening the general population for the risk marker albuminuria greater or equal to 15mg/24hr and subsequent treatment with foscarnet of those found positive to reduce the incidence of CV events may well be cost effective.

**PUK9**

**COST-EFFECTIVENESS OF PARICALCITOL IN THE TREATMENT OF SECONDARY HYPERPARATHYROIDISM: THE EXPERIENCE IN ITALY**

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OBJECTIVES: To evaluate short-term (12 months) cost-effectiveness (CE) of intravenous (iv) Vitamin D preparations (paricalcitol and calcitriol) to control hyperparathyroidism in hemodialysis patients. METHODS: A decision analytic model was constructed and analysed from the hospital and the Italian National Health System (INHS) perspectives. Following the indications of the Italian Nephrology Society on the use of iv Vitamin D analogues, patients were simulated to start a 12-month iv Vitamin D treatment when parathormone (PTH) plasmatic level was >700pg/ml. Starting doses were 27µg/week for paricalcitol and 9µg/week for calcitriol; subsequent maintenance dose was adjusted assuming decreasing PTH levels over time. Model parameters were derived from multiple published sources. Clinical course of treatment and efficacy in controlling hyperparathyroidism were based on a RCT (Sprague SM. Kidney Int 2003); effect on survival, hospitalisation rate and length-of-stay (LOS) were based on retrospective studies (Teng M. NEJM 2003; Dobrez DG. Nephrol Dial Transplant 2004). Cost included drug costs (hospital prices excluding taxes), cost per hospitalization (national mean DRG value, 2002), in the INHS perspective, or cost per day of hospitalization (general medical ward, Lucioni C. et al. Treat Endocrinol 2003), in the hospital perspective. RESULTS: Per patient one-year drug acquisition costs were €3364.74 for paricalcitol and 1883.25 for calcitriol. Calcitriol patients had an average of 0,846 hospitalizations/year more than paricalcitol at an incremental cost, in the INHS perspective (DRG tariffs), of €2868.69. Calcitriol patients had an average of 9.17 hospitalization/days more than paricalcitol at an incremental cost, in the hospital perspective (LOS), of €2249.58. Paricalcitol strategy resulted dominant in both perspectives. Robustness of these findings was demonstrated in multiple sensitivity analyses. CONCLUSIONS: In Italy, paricalcitol greater acquisition costs are offset by reduction in hospitalizations and LOS both from an NHS perspective and from the hospital perspective.

**PUK10**

**COST-EFFECTIVENESS OF MIMPARA AMONG DIALYSIS PATIENTS IN BELGIUM USING A MARKOV SIMULATION MODEL**

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OBJECTIVES: To demonstrate cost-effectiveness (ICER) of Mimpara (MIM), a drug against secondary hyperparathyroidism (sHPT) in dialysis, compared to standard treatment of care (SOC). METHODS: A Markov model operates in 1/2 year cycles and runs over 16 years until the starting cohort reaches 70 years. Mortality risk per cycle was calculated from a 2-year cohort dialysis database (n = 13,000)1. The model uses specific distributions for parathyroid hormone (PTH), Calcium (Ca) x Phosphor (P), age, vintage and MIM dosages (30–120mg/day) from phase III trials. Patients withdrawing from MIM were treated with SOC. Average drug costs were €3109/year first cycle and €2617/year subsequent cycles as only drug responders (85%) remained on study drug. Other treatment costs were taken from a retrospective cost study in Belgium2 using average daily cost of €21 per dialysis patient plus €50/day for sHPT-sufferer. Annual 3% discount rate was applied to cost and outcome data. RESULTS: Running the model in Monte-Carlo simulation (10,000 iterations) over 16 years, delivered a mortality difference of 0.17 years favoring MIM-use for an extra cost of €8027 (+ dialysis cost) resulting in an ICER of €47,218 per Life Year Gained. Excluding dialysis costs the ICER was €36,970. Sensitivity analyses ranges discount rates from 0% to 6% independently for both outcome and cost data showed ICERs of €36,970 and €59,459 for outcome and €64,517 and €35,088 for cost results, respectively. Evaluating the ICERs over time indicates that cost savings may appear early in MIM-treatment (first 2 to 3 years) due to reductions in co-morbidities without observable survival benefit. CONCLUSION: Including dialysis costs in the ICER-equation maintained a reasonable CE-result (<€50,000/LYG) favoring the use of Mimpara for sHPT.