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 €1,391 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 ATEROTHERMOTRIC 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, 1VD) 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, 6VD) 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