based on a societal perspective, was assessed for women with menopausal symptoms. METHODS: An individual state transition model populated Swedish data was used to estimate the cost-effectiveness of women with menopausal symptoms. The model consists of the following disease states: Coronary Heart Disease (CHD), Stroke, Venous thromboembolic events (VTE), breast cancer, colorectal cancer, hip fracture, vertebral fracture and wrist fracture. HRT therapy was modelled by its impact on the disease risks during therapy and possible effects after the cessation of therapy. The model calculates costs and health effects or quality adjusted life years (QALYs) with and without intervention. The resulting cost per gained QALY was compared to the value of a gained QALY, which was set to 65,000€.

RESULTS: The cost per QALY gained for Swedish women with intact uterus and menopausal symptoms were estimated to 1404€, 1188€, and 1004€ when the therapy started at the age of 50, 55, and 60, respectively. The cost per QALY gained was found to be below the set value of a QALY at very low symptom related reductions in the quality of life. CONCLUSIONS: The results indicate that there is high probability that HRT is cost-effective for the treatment of women with menopausal symptoms.

**ACUTE COSTS OF STROKE IN THE UK NATIONAL HEALTH SERVICE IN 2002–2004**

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**OBJECTIVE:** Stroke is a major cause of morbidity, health service use, and death in the UK. Previous studies report substantial associated costs, particularly related to hospitalisation. However, no previous UK analysis has used data from a population-based incidence study with full case ascertainment, without which major inclusion bias is likely. Using data from such a study, we estimate the acute costs per patient over the first year from initial stroke, by severity of stroke and prior atrial fibrillation.

**METHODS:** Event and hospitalisation (inpatient or outpatient) data were obtained from the Oxford Vascular Study, a prospective cohort study of all individuals in 9 general practices in Oxfordshire, UK, which identified 346 patients experiencing a stroke from April 1, 2002–March 31, 2004. Transient ischaemic attacks were excluded. Mean costs per patient were calculated, adjusting for censoring. **RESULTS:** In all, 212 (62%) patients were admitted, the remainder being managed in the outpatient clinic. The mean censoring-adjusted cost per patient was £8508, 69% of which was incurred within 60 days after the index event. Patients with stroke recurrence in the study period incurred costs of £7881 compared to £6089 in those without.

**OBJECTIVES:** Beta-blockers have provided evidence of improving survival in chronic heart failure (CHF) patients. Specifically, the Cardiac Insufficiency Bisoprolol Study II (CIBIS-II) has demonstrated a significant reduction in mortality and morbidity among patients with moderate to severe CHF treated with bisoprolol. Our aim was to investigate the economic consequence of bisoprolol therapy in CHF patients in Italy. **METHODS:** Data were derived from the CIBIS-II trial. We conducted a cost-effectiveness analysis, comparing standard care + bisoprolol vs standard care + placebo in the perspective of the Italian National Health Service (NHS). We identified and quantified medical costs: drug costs according to the Italian market price; specialist visits for initiation and up-titration of bisoprolol therapy and hospitalizations were quantified on the basis of the NHS tariffs (2004). Effects were measured in terms of mortality and morbidity reduction (number of deaths, life years saved and frequency of hospitalizations). We considered an observational period of 1.3 years that was the average follow-up recorded in the trial. Discounting was not performed because of the relatively short follow-up of patients. We conducted one-way sensitivity analyses on unit cost and effectiveness. **RESULTS:** The overall cost per 1000 patients treated for 1.3 years was estimated in 2,043,700€ in the bisoprolol group and in 2,366,168€ in the placebo group, resulting in a net saving of 322,468€. The number of additional patients alive with bisoprolol was 55 per 1000 patients, the number of LYS was 36 at 1.3 year. **CONCLUSION:** Bisoprolol therapy is dominant since it is both less costly and more effective than standard care. Results of sensitivity analysis showed that bisoprolol therapy remains dominant even to changes in unit cost of drug, hospitalizations and frequency of hospital admissions.