health-care context was developed, based on the use of epidemiological and clinical data obtained from literature and local data on health-care resource utilisation and health-care unit costs. Only direct medical costs were analysed. The perspective of the health-care payers (sick funds and patients) and a time horizon of six months were taken. The target population was RA patients aged 55, with an average risk of 9-12 points using Fries calculator. Effectiveness was expressed in terms of the number of patients free of symptomatic ulcer. On this basis, saved lives and life years gained were calculated. The cost-effectiveness threshold, calculated on the basis of one-year haemodialysis treatment cost of 60000 PLN (1 USD = 4 PLN), was determined to assess whether celecoxib therapy should be adopted.

RESULTS: The cost-effectiveness analysis showed that celecoxib treatment of RA patients gives additional life years for extra costs. The cost per symptomatic ulcer or death averted for celecoxib, compared with diclofenac, were 20431 to 20676 and 600887 to 608887 PLN respectively. In the study population, 1 LYG costs 32300 PLN and is below the suggested threshold. One-way sensitivity analysis showed that results are sensitive to changes in price of celecoxib and the probability of NSAID-induced GI events. The threshold analysis suggests that celecoxib would be the dominant therapy if its cost or daily dose were to decrease by 60%.

CONCLUSION: The treatment with celecoxib vs. diclofenac 75 SR in RA may be cost-effective in Poland. Cost/ LYG was below the suggested cost-effectiveness threshold, if avoidance of 1 death generates more than 10 LY.

COST-EFFECTIVENESS ANALYSIS OF USING CELECOXIB IN THE TREATMENT OF OSTEOARTHRITIS
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OBJECTIVE: To ascertain the efficiency of Celecoxib versus non-steroidal anti-inflammatory drugs (NSAID) in treating osteoarthritis.

METHODS: The study was performed using a decision analytic model that represents the daily medical practice in our country by running two hypothetical cohorts of 10,000 patients either with Celecoxib or any NSAID. The simple decision tree of the model has two different branches: a) Celecoxib, and b) NSAID, divided into NSAID + gastroprotective agents and NSAID alone. Each branch may follow different clinical evolutions: no adverse reactions; appearance of gastrointestinal (G-I) discomfort; symptomatic ulcers, and severe G-I complications followed by death. The probabilities for the development of these adverse events have been obtained from medical literature, national statistics (life expectancy) and a local expert panel. The effectiveness unit chosen was life-years gained after the use of both options. Only direct costs were included (medications, additional examinations and analytical tests, days of hospitalization, treatment of ulcers and G-I complications). The time horizon was six months and the perspective selected was the Spanish National Health Service (NHS).

RESULTS: The total cost of the cohort treated with Celecoxib was 570,456,110 pesetas (US $2,955,731) while in the cohort treated with NSAIDs this amounted to 340,328,814 pesetas (US $1,763,361). In the Celecoxib