mias. Health-care utilization and cost data for each of the two patient categories were averaged and annualized. Costs were converted from local currencies to Euros. RESULTS: The mean annual health-care costs in patients with bradycardia alone was 7,787 EUR (95%CI 6,176 to 10,040 EUR) in the US, 3,860 EUR in Germany, and 3,765 EUR in the UK compared to 22,043 EUR (95%CI: 15,060 to 30,759 EUR) in the US, 14,720 EUR in Germany, and 10,407 EUR in the UK for patients with bradycardia and atrial tachycardias. Atrial tachycardia results in an additional two- to three-fold increase in costs per year. The main cost driver in the US and Germany was hospitalizations whereas the main cost driver in the UK was the cost of procedures. CONCLUSION: Atrial tachyarrhythmias impose a large incremental burden on health-care utilization and costs in bradycardia patients.

**EFFECT OF AMLODIPINE TREATMENT ON CARDIOVASCULAR DISEASE-RELATED HOSPITALIZATIONS AND COSTS IN PATIENTS WITH CORONARY ARTERY DISEASE IN SPAIN**

**Galduf J1, Rejas J2, Arocho R3, Arístegui R4**

1Pfizer and Pompeu Fabra University, Barcelona, Spain; 2Pfizer, Madrid, Spain; 3Pfizer Ltd, New York, NY, USA

OBJECTIVE: The purpose of this study was to examine the effect of amlodipine treatment on cardiovascular disease (CVD) related hospital admissions and the corresponding costs in patients with coronary artery disease (CAD) in Spain.

METHODS: This analysis used data from Prospective Randomized Evaluation of the Vascular Effects of Norvasc Trial (PREVENT), a double-blind, randomized, placebo-controlled, multi-center clinical trial. A decision-tree model was used to analyze the expected incremental cost of amlodipine treatment relative to placebo. A sensitivity analysis was conducted to examine the robustness of the study outcome. The hospital costs were estimated using the DRG’s from the Medicare adjusted to the median of a local hospital stay cost (Catalonian area).

RESULTS: Amlodipine significantly reduced the number of CVD-related hospital admissions and procedures in patients with CAD relative to placebo. The expected CVD-related hospital cost per patient in the placebo group exceeded costs for patients in the amlodipine group. The expected savings of CVD-related hospitalizations ranged from 0 to 331 Euros per patient over the trial period in 1997 Spanish pesetas when the cost to charge ratio was changed from 0.66 to 1.2. The total expected costs for the amlodipine group were 1,723.5 Euros (533 for no CVD hospitalization and 1,190 for CVD hospitalization) while the total expected costs for the placebo group were 1,929 Euros (119 for No CVD hospitalization and 1,810 for CVD hospitalization). At the breakeven point (the cost to charge ratio = 0.66), the amlodipine treatment still offset the drug cost of amlodipine.

CONCLUSIONS: Use of amlodipine can reduce CVD-related hospital admissions and associated costs in patients with coronary artery disease. Amlodipine is a cost-saving agent in the treatment of patients with coronary artery disease.

**COST-OF-ILLNESS STUDY OF UNSTABLE ANGINA PECTORIS IN GERMANY**

Smala A1, Schramm B1, Karmann B2, Wendel-Busch J3, Berger K1

1MERG - Medical Economics Research Group, Munich, Germany; 2Essex Pharma GmbH, Munich, Germany

OBJECTIVES: To install a world-wide-web (WWW, internet) -based registry for the observation of treatment patterns for unstable Angina Pectoris (uAP) and to estimate the economic burden of uAP in Germany from the perspective of the statutory health insurance (Gesetzliche Krankenversicherung) and of hospitals as service providers.

METHODS: Prospective, bottom-up, cross-sectional cost-of-illness (COI) study. Three hundred sixteen patients consecutively included between November 2000 and May 2001 were documented via an Internet-based registry using standardized documentation forms. Inclusion and exclusion criteria were pre-defined. Fifteen centers of different healthcare levels (10 university hospitals, 1 specialized hospital, 4 general hospitals) participated. Direct costs (for diagnostic, medical treatment, surgery, drug therapy) and indirect costs (due to lost productivity) associated with inpatient treatment due to uAP were considered.

RESULTS: Mean age of patients was around 65 years for females (34%) and 69 years for males (66%). In about 99% of cases, uAP was diagnosed at hospital admission: 47% were hospitalized as emergency cases; 26% were referred from other hospitals; 26% from office-based physicians. Mean hospital stay lasts 8.3 days per patient, 6.8 days of them spent in intensive care. Angiography or angioplasty were performed on 78% of patients. About 4% of patients underwent heart surgery, most of them for triple coronary bypass. 30% of patients received one of the new platelet aggregation inhibitors (Abciximab, Eptifibatide, Tirofiban) during hospitalization.

CONCLUSIONS: Because the registry is still ongoing, cost data are under evaluation, but will be finalized for poster presentation. Treatment with platelet aggregation inhibitors is still not very common, despite being recommended by German therapy guidelines for uAP treatment.

**CHRONIC VENOUS INSUFFICIENCY (CVI) IN POLAND—A COST OF ILLNESS STUDY**

Czech M, Faluta T, Pachocki R

Servier Polska, Warsaw, Poland

OBJECTIVE: With a prevalence up to 40% in the adult population, chronic venous insufficiency (CVI) is one of
ECONOMIC EVALUATION OF ENOXAPARIN IN PATIENTS WITH ACUTE MEDICAL ILLNESS: AN ITALIAN ECONOMIC STUDY FROM THE MEDENOX TRIAL

Nuijten M1, Berto P2, Kosa J3, Nadipelli V1
1Medtap International, Jisp, Netherlands; 2PBE Consulting, Verona, Italy; 3Aventis Pharmaceuticals, Inc, Bridgewater, NJ, USA

OBJECTIVE: To generate estimates of the cost-effectiveness of thromboprophylaxis with enoxaparin versus no thromboprophylaxis (usual care) in patients with acute medical illness in the health-care setting of Italy from the NHS perspective.

METHODS: Markov process analysis techniques were used to model the health-economic outcomes. Data collection was based on probabilities of clinical events from clinical trial data from the MEDENOX trial and other published literature, OECD country-specific general population mortality and Delphi panels. Units of health-care utilization were derived from the Delphi panels. Prices and tariffs were derived from official lists.

RESULTS: Analysis over one year showed that the cost per venous thromboembolic (VTE) event avoided was Lit4,500.586 (EURO2,324) and cost per life saved was Lit16,042.624 (EURO8,285), when assuming no higher risk for morbidity and mortality for asymptomatic patients. The lifetime model (again, assuming no higher risk for morbidity and mortality for asymptomatic patients), showed that enoxaparin increased the total costs from Lit804,900 (EURO416) to Lit1,180,000 (EURO609), while the life expectancy increased from 14.11 to 14.43 years. Consequently, cost per life year gained was Lit1,180,000 (EURO609), and the cost per event avoided was Lit4,343,446 (EURO2,243).

CONCLUSION: The results showed that the favorable clinical benefit of enoxaparin observed in MEDENOX...