equipment costs ($495 list price of Revoke per use) and depreciated cost of centrifugation ($525 10-unit difference) were also estimated. RESULTS: Base case assumed 100 AFGo per year (150ml of fat injected per case). Mean time to complete AFG was substantially faster using Revolve than centrifugation: 29.1 minutes versus 116.1 minutes (range: 25.1-32.0 versus 104.1-125.8 minutes, respectively). Mean time to complete AFG was greater for Revolve than centrifugation: 5.2mL/min versus 1.3mL/min (range: 4.7-6.0 versus 1.2-1.4mL/min, respectively). Estimated cost savings for Revolve versus centrifugation was $2,075 per case and $207,476 per year. CONCLUSIONS: As popularity of AFG increases, evaluating economic impact of AFG systems becomes essential. Based on current findings, Revolve system results in substantial OR time and cost savings compared to centrifugation.

**PM75**

**INTEGRATING BIG DATA TO ASSESS THE ECONOMIC IMPACT OF THE IMPLANTABLE CARDIOVERTER DEFIBRILLATOR THERAPY**

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OBJECTIVES: The main purpose of this study was to link clinical and administrative healthcare databases in order to assess the economic impact of implantable cardioverter defibrillator (ICD) with or without cardiac resynchronization pacing (CRT-D) in Lombardy, the most populated Italian region providing universal health-care coverage for about 10 million inhabitants. METHODS: Data were extracted from: i) data warehouse DENALI, that organizes healthcare administrative databases concerning all subjects covered by Lombardy Health System (HS), ii) national ICD database of patients implanted by DENALI and ICD information extracted from national ICD database, we identified patients with ICD and followed them from the date of the first implant to 12/31/2010, recording hospitalizations, drugs and outpatient claims. Direct healthcare costs were analysed from the perspective of the HS. We estimated annual mean per-capita costs after the first ICD implant: overall and stratified by indication (primary and secondary prevention) or type of implanted device (single-chamber and CRT-D). During the follow-up, 12,525 subjects underwent a first ICD implant. Mean annual per-capita cost during follow-up was $6,086 (95%CI: $5,970-6,211). 72.7% due to hospitalizations ($4,422, 15.7% to pharmaceutical therapies ($957) and 11.6% to outpatient services ($706). No direct costs were assigned to devices between the mean annual expenditure for primary (16,179; 95% CI: 6,001-6,353) and secondary ($5,996, 95% CI: 5,821-6,185) expenses. As for the type of implanted device, patients with CRT-D cost more than those with single-chamber or dual-chamber: respectively $6,592 (95%; 6,376-8,497), $5,728 (95%; 5,541-8,972) and $5,932 (95%; 5,717-11,767). The difference was attributable to hospitalization expenses. CONCLUSIONS: ICD use is growing and it is important to assess the efficacy and the burden of this therapy, given its economic implications. Combination of both clinical information from national ICD database and big administrative data could overcome the limitation of both data sources, leading to an improvement in the monitoring of ICD therapy.

**PM76**

**ECONOMIC AND PATIENT BURDEN OF LIPOHYPERTROPHY IN CHINESE PATIENTS WITH DIABETES**

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OBJECTIVES: This study aimed to evaluate the economic and patient burden of lipohypertrophy (LH) in China. METHODS: An observational study was conducted among 401 insulin-injecting adult patients with DM from 4 cities, 2 with and 2 without pen needle reimbursement (PNR). This study included demographics, medical history, direct and indirect costs, insurance and PNR status. RESULTS: LH was present in 52.9% of patients. Patients were an average of 58 (SD 11.5) years old and took insulin 5 times (SD 4.6) per day, averaging 33.0 (SD 12.9) U/day. HbA1c was 8.2% (1.8) and 7.1% (1.5), respectively, in those with and without LH (p = 0.003). LH was associated with higher dose insulin (38.1U vs 27.1U, p = 0.003). Mean LH was 18.4 (SD 0.1) U/day. HbA1c was 8.2% (1.8) and 7.7% (1.5), respectively, in those with and without LH (p = 0.003).

**PM77**

**ECONOMIC ANALYSIS OF EVARESTTM COMPARED TO TACHOSIL IN LIVER AND OTHER SURGICAL BLEEDING: AN INDIRECT COMPARISON**

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OBJECTIVES: Surgical bleeding remains prevalent and associated with substantial burden. Such bleeding can be more difficult to manage in certain surgeries (e.g., liver). Hemostats with a fibrinogen, thrombin and patch component may be especially beneficial for problematic bleeding types; however, direct comparative data are limited. This study indirectly compared the hemostats EVAREST® and TachoSil®. METHODS: A structured literature search identified studies of fibrin sealants combined with use of a pad, patch, fleece or sponge, for surgical bleeding. The search was restricted to RCTs, 2000 onward, studies including standard of care (SoC) and time to hemostasis (TTH). EVAREST® (4 trials) and TachoSil® (6 trials) were identified as the comparators. Pair-wise meta-analyses were completed using a random-effects model for hemostat vs. SoC. An adjusted indirect comparison was conducted using Bucher methodology and ITC software (Wells, 2009) for calculating Hedges g, a measure of difference between EVARREST and TachoSil. 95% confidence intervals (CI). Mean TTH was analysed as it was a well-accepted, recommended measure. Typically, TTH measurements began at either 3 or 4 minutes. Six studies, labeled as the “anchor” study, those that demonstrated EVAREST® was equal to or inferior to either of the conventional methods or topical hemostats. Indirect comparisons were completed for all surgery types and a liver surgery subgroup. RESULTS: A total of 894 patients were assessed. Across surgery types, the adjusted indirect comparison demonstrated that EVAREST® reduced mean TTH by 1.15 minutes compared to TachoSil® (95%CI: -1.15, 0.99). This difference was not statistically significant. In the subgroup of liver surgery bleeding, EVAREST® significantly reduced mean TTH by 2.73 minutes (MD: -2.73, 95%CI: -4.48, -0.98). CONCLUSIONS: This analysis suggests EVAREST® may provide better hemostasis than TachoSil, particu-