structures vary by IOP threshold values. Day-time IOP control with PGAs is associated with night-time IOP control whatever the IOP threshold.

PEY2

INTRA-OCULAR PRESSURE CONTROL OF XALACOM ® (FIXED LATANOPROST AND TIMOLOL COMBINATION) AND DUOTRAV ® (FIXED TRAVOPROST AND TIMOLOL COMBINATION) IN DAILY PRACTICE

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OBJECTIVES: To confirm, in everyday practice, results from randomized clinical trials indicating that DuoTrav (a fixed travoprost and timolol combination) controls intra-ocular pressure (IOP) better than Xalacom (a fixed latanoprost and timolol combination), even when measured >24 hours after last instillation. **METHODS:** Patients with ocular hypertension or primary open angle glaucoma and treated by one of the above combinations were included in this cross-sectional study. Demographics, medical history and previous treatments were abstracted from medical records. IOP and treatment time were collected during an office visit. Analyses of variance, logistic regressions and propensity scores were used to adjust for confounding factors. **RESULTS:** In total, 328 patients were included, 127 treated with DuoTrav and 201 with Xalacom. The mean age was 64.6 years and 51.5% were female. Most (275: 84.6%) had last instilled treatment the previous day. Treatment groups were comparable except that Xalacom-treated patients had longer disease and treatment durations. Overall mean IOPs were 24.9 mmHg at diagnosis and 21.1 mmHg upon starting the fixed combination treatment. There was no significant difference between the groups as they started their second line therapy. Duotrav-treated patients experienced better IOP control (17.1 versus 19.1 mmHg: $p < 0.001$). A difference was also noted for patients who missed their last scheduled treatment (17.2 versus 20.1 mmHg: $p < 0.006$). Better IOP control with DuoTrav was further supported by patients whose last instillation was 9.00–12.00 hours before IOP measurement (16.5 versus 19.3 mmHg; $p < 0.001$). According to the practitioners, 83.1% of the DuoTrav-treated patients attained their IOP targets, as compared to 51.3% of Xalacom-treated patients ($p < 0.001$). All these differences persisted after adjustment for confounding factors. **CONCLUSION:** This everyday practice study paralled the published corresponding prostaglandin results of Topouzis and DuBiner, i.e. compared to Xalacom, IOP control with DuoTrav is better and has a longer residual effect when measured >24 hours later.

EYE—Cost Studies

PEY3

RANIBIZUMAB (LUCENTIS®) IS A COST-EFFECTIVE TREATMENT OF AGE-RELATED MACULA DEGENERATION (AMD) IN THE GERMAN HEALTH CARE SYSTEM

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OBJECTIVES: The rationale for this study was to provide data for the German health care system in order to investigate the assumption that ranibizumab is a cost-effective option for the treatment of neovascular AMD. **METHODS:** We modeled cost-effectiveness for ranibizumab-treatment of the patient's "better" eye based on the development of visual acuity in our phase III studies (ANCHOR/MARINA) compared to a control group who received best supportive care (e.g. visual aids, regular check-ups). In the base-case, we computed 6 treatments per year for 2 years and used the same patient entry age (77 years) and distribution of visual acuity of the model population as in our phase III studies. Utility values came from a study by Brazier et al. Costs and benefits were discounted annually at 5%. Costs of drugs and treatment procedures were determined based on German pharmacy retail prices, the German code book for physicians' fees (EBM 2000plus) and German DRGs. We conducted a sensitivity analysis in order to test the stability of our model assumptions. Variations of the base-case scenario included e.g. patient age: 50–85 years, visual acuity at start of therapy: btw. > 4.0 and 0.05–0.1 or duration of therapy: 1–3 years. **RESULTS:** The base-case scenario yielded the following costs per QALY: 16.882 € for predominantly classic lesions, 24.766 € for minimally classic chorioidal neovascularization (CNV) and 26.170 € for occult CNV. When weighing the costs per QALY according to the distribution of these lesion types (18%–25%–57%), the mean costs per QALY for the therapy of wet AMD with ranibizumab amount to 24.147 €. The treatment was cost-effective even under adverse conditions, e.g. longer treatment duration, high visual acuity at start of treatment, high patient age, increased costs per injection. **CONCLUSION:** Therapy of neovascular AMD with ranibizumab is cost-effective for all angiographic subtypes assuming a realistic variation of model parameters.

PEY4

COST-EFFECTIVENESS ANALYSIS OF FIXED COMBINATION THERAPIES GANFORT, DUOTRAV AND XALACOM IN EUROPEAN COUNTRIES

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OBJECTIVES: Ganfort is a fixed combination product containing bimatoprost 0.03% and timolol 0.5% indicated for lowering IOP of patients with glaucoma or ocular hypertension. Other fixed combination products such as Xalacom (latanoprost 0.005% and timolol 0.5%) and Duotrav (travoprost 0.004%and timolol 0.5%) are also available on the market. All products have the advantage of being more convenient for the patient due to once-daily administration. Since no head to head studies compare the three combination products, an indirect comparison is used based on available clinical data. The purpose was to investigate the cost-effectiveness of the three fixed combination therapies in eight European countries. **METHODS:** A systematic literature search was conducted in order to identify randomized clinical trials of Duotrav and Xalacom. Studies were selected which had reduction in IOP as primary endpoint and which were comparable with data from randomized controlled trials of Ganfort with respect to study design, diagnosis and patient population, so that an indirect comparison could be conducted. A decision analytic cost-effectiveness model was constructed. The cost evaluated was cost of medication and clinical visits to an ophthalmologist. All drug costs are market prices inclusive of VAT and visit costs are priced using official tariffs. Patients discontinuing treatment due to adverse events were assumed to change therapy and had an extra clinical visit. **RESULTS:** The cost-effectiveness analysis showed that the cost per percentage reduction in IOP was least costly for Ganfort. By using Ganfort therapy, savings per percentage reduction in IOP ranged from €0.06 to €0.22 compared to Duotrav and €0.02 to €0.36 compared to Xalacom. **CONCLUSION:** This analysis concludes that