# Abstract

**Background:** Atrial fibrillation (AF) is common and increases stroke risk. Echocardiography is commonly performed as part of the cardiological evaluation of patients with AF expecially to assist with stroke risk stratification (and hence, decisions on thromboprophylaxis with oral anticoagulants (OACs)). The cost effectiveness of such an approach is unknown.

**Objective:** To estimate the cost-effectiveness of using transthoracic echocardiography (TTE) in helping to make the decision whether to prescribe an OAC in newly diagnosed AF patients.

**Design**: Diagnostic economic modeling analysis.

**Setting:** United Kingdom.

**Model:** Diagnostic discrete event simulation model.

**Comparisons:** Decisions and consequences following from using TTE in combination with CHADS2, a standard clinical decision tool, were compared with those when using CHADS2 alone.

**Treatments considered:** warfarin, dabigatran and rivaroxaban were all considered separately as OACs which may be prescribed as a result of the information provided by TTE.

**Population:**  Newly diagnosed AF patients. Cohorts were simulated where the CHADS2 scores alone would not lead to a decision to prescribe OACs. Ten different patient and OAC scenarios were considered, exploring the effect of OAC, age, and gender on the cost-effectiveness of this use of TTE.

**Main outcome measures**: Quality adjusted life years (QALYs) gained, strokes averted, effects on cost and major bleeding events.

**Results:** For younger patients, newly diagnosed aged 50 years, using TTE to help inform the OAC prescription decision does not appear cost effective, and is predicted to be both more expensive and less effective than not using TTE due to additional overtreatment. For older newly diagnosed AF patients, aged 65 years, using TTE is more effective but more expensive. The incremental cost-effectiveness ratios (ICERs) depend on the OAC being considered and gender, and are at or below conventional NICE willingness-to-pay thresholds when a newer OAC (rivaroxaban or diabigatran) is being considered, but much above this threshold when warfarin is being considered.

**Conclusions:** Using TTE to inform the decision whether to prescribe a newer OAC to newly diagnosed AF patients may be a clinically and cost-effective strategy.

# Introduction

## Background

Atrial fibrillation (AF) is a common arrhythmia affecting around 1-2% of the UK population and is a significant risk factor for stroke.[1] Effective management of AF and the associated stroke risk is important for reducing mortality and morbidity risks that result from this arrhhythmia. Oral anticoagulants (OACs) reduce the risk of stroke, but could potentially cause major bleeding. [2]

As well as exposing patients to a risk of major bleeding events, OACs impose a cost burden, either directly due to drug acquisition costs in the case of newer OAC drugs like dabigatran or rivaroxaban, or indirectly due to monitoring costs in the case of warfarin. It should be noted that even where an intervention is clinically effective it does not necessarily follow that it is also cost effective. If the risk of stroke in the patient is low, then the increased health risks associated with OACs may outweigh the benefits, and so a range of diagnostic tools are used to identify higher-risk patients, including clinical prediction rules using patient history and characteristics.

A commonly used risk prediction rule for assessing stroke risk is the CHADS2 score, which is an acronym for (C) congestive heart failure, (H) hypertension, (A) aged 75 years or older or (D) diabetes; and prior stroke, transient ischemic attack (S2) [3] In the 2010 European guidelines, if the CHADS­2 score is one point or over, the OAC should be prescribed. In patients with a CHADS2 score of zero, additional risk factors such as being between over 65 years old, being female, and vascular diseases should be considered as part of the CHA2DS2-VASc score. [3] The latter score is the only recommend stroke score in the 2012 focused update of the ESC guidelines. [4]

## Transthoracic Echocardiography and the decision problem

The present study assesses whether performing an additional, slightly more expensive diagnostic test in the population of interest would lead to better clinical outcomes on average. The populations to be modelled are patients with newly diagnosed AF and an initial CHADS2 risk score of zero points, since those with CHADS2 scores greater are likely to be treated without requiring further diagnostic testing. If additional testing is clinically effective, it is also important to evaluate whether it is cost effective at standard NICE decision-making thresholds. The additional diagnostic test of interest is transthoracic echocardiography (TTE), a non-invasive procedure that allows imaging of the heart and blood flow. Importantly, it can detect some forms of left atrial abnormality (LA ABN), which has been shown to lead to an increased stroke risk. [5,6] As some types of LA ABN can be detected by TTE, but not by CHADS2, TTE can be used to identify patients with a higher risk of stroke who otherwise may not receive OACs. In this study a discrete event simulation (DES) model was developed to simulate the long-term implications of performing TTEs in the population of interest when deciding whether to prescribe OACs. Patients whose CHADS2 scores are below the threshold at which the OAC would be prescribed are additionally assessed using TTE. If TTE indicates a LA ABN they are also prescribed OACs. As a result of this, more people will be prescribed OACs when TTE is included in the diagnostic package than when it is not. The use of TTE will increase expenditure, however, potential cost savings could arise as a result of preventing strokes and the costs to the NHS that result from them.

# Methods

The mathematical model developed estimated the consequences of using TTE to inform the decision whether to prescribe an OAC in a range of patient populations. Eight distinct cohorts were modelled, and separate scenarios were performed for each of three potential OACs: warfarin, dabigatran, and rivaroxaban. These are listed in Table 1. The health economic outcome of interest is the quality adjusted life year (QALY). A UK perspective is adopted, with costs incurred by the patient or wider society not considered. Standard NICE discount rates for utilities and costs of 3.5% per annum are used. [7] A lifetime horizon is adopted, and in order to incorporate the effect of uncertainty on predicted outcomes, a probabilistic model is used, meaning that where possible model parameter estimates are drawn from distributions rather than assumed to be fixed values.

## Scenarios included

Warfarin, rivaroxaban, and dabigatran are each recommended in patients with different clinical characteristics. Warfarin is recommended in patients with a CHADS2 score of one or more; the recent NICE recommendations for rivaroxaban are equivalent to stating that patients with a CHADS2 score of one or more should receive it; and recent NICE recommendations for dabigatran are equivalent to stating that patients with a CHADS2 score of one or more should receive it if they are also aged 65 years or more[8,9]. The scenarios in which a TTE may affect the OAC decision are described in Table 1.

[Table 1 about here]

## Model Overview

An overview of the model is presented in Figure 1. The model comprises a short-term diagnostic stage and a long-term patient outcome stage. In the short-term stage the clinical characteristics of a patient are generated, and whether or not an LA ABN was identified and hence an OAC was prescribed is determined. In the long-term simulation the patient’s clinical outcomes are simulated. Over the patient lifetime the patient may experience a stroke or major bleeding event, both of which could cause death; patients may also die from another cause. Each of these events has associated cost and utility implications. By simulating the outcomes for a large number of patients, the average associated costs and utilities following alternative diagnostic strategies (with and without the use of TTE) were estimated, allowing estimation of the mean costs and mean QALYs for both strategies, and from these the incremental cost effectiveness ratio (ICER) of including TTE in the diagnostic package.

In the baseline strategies, none of the patients with LA ABN were treated with the OAC even though their high stroke risk means that the benefits would on average outweigh the risks. In the comparator strategy, a percentage of these patients with LA ABN would receive the OAC due to TTE correctly identifying LA ABN, dependent on sensitivity of TTE. However, when specificity is less than perfect a proportion of patients without LA ABN would also receive it.

In the short-term diagnostic stage of the model the population are divided into true positives (TPs), true negatives (TNs), false positives (FPs) and false negatives (FNs). The relative size of each of the four groups is a function of the proportion of the population with LA ABN, referred to here as the true proportion high risk (TPHR), and the sensitivity and specificity of the diagnostic technology. These are defined as follows:

* Proportion of true positives = TPHR x sensitivity;
* Proportion of true negatives = (1 –TPHR) x specificity;
* Proportion of false positives = (1 – TPHR) x (1 – specificity);
* Proportion of false negatives = TPHR x (1 – sensitivity).

Within the context of the model, the baseline strategy (no TTE) can be considered a diagnostic strategy with a sensitivity of zero and a specificity of one, so the baseline population mix comprises TPHR false negatives and the remainder (1 - TPHR) true negatives.

## Modelling long-term events

Prescribing an OAC reduces the risk of stroke, but increases risk of a potentially fatal major bleeding event. Three mutually exclusive outcomes could result from a stroke: death; a dependent state; and an independent state. Each outcome has different health related quality of life (HRQoL), probabilities and costs. Similarly, three mutually exclusive outcomes could result from a major bleeding event: death; an intracranial (IC) bleeding event; or a non-intracranial (NIC) bleeding event (assumed to be a gastrointestinal bleed). The severity of an IC bleed can vary substantially, and this variation of outcomes was itself simulated using data based on outcomes categorized by Glasgow Outcome Scale (GOS) score following traumatic brain injury. The full methodology used to produce these estimates is presented elsewhere. [10]

The model is updated when events occur that affect an individual’s stroke or bleed risk. Examples of such events are: experiencing a stroke; withdrawal of an OAC following a major bleed; and reaching 75 years of age, which increases the CHADS2 score by one point. It was assumed that if a patient experiences a stroke and is not already taking an OAC, they are prescribed OACs, provided they have not experienced a previous bleeding episode. If a patient suffers a severe intracranial haemorrhage (Glasgow Outcome Scale category 2) as a result of taking OACs, their life expectancy was reduced to a maximum of 3.6 years with no QALY gain. [11] Additionally, the risk of a major bleeding event when taking dabigatran (150mg twice daily) was also assumed to change at the age of 75, as indicated by recent evidence comparing dabigatran with warfarin. [12]

## Data sources used in model

A full list of the information used to populate the parameters in the model, including event risks, costs and utilities, is presented in Table 2.

## Estimating cost effectiveness

The scatterplots of estimates produced by the PSA provide an indication of the clinical and cost-effectiveness of the TTE option compared with the no TTE option. If the majority of the scatter are in the north west quadrant of these graphs, then this indicates that the TTE option is both more costly and less effective than the no TTE option, and this is said to be ruled out by simple dominance. Scatter in the north east quadrant indicates that, compared with no TTE, TTE is both more expensive but also more clinically effective; in these cases, it is important to identify whether the ratio of incremental costs to incremental benefits – the incremental cost-effectiveness ratio (ICER) - is below a given threshold value, defined as maximum acceptable incremental cost effectiveness ratios (MAICERS). Treatment options are usually described as ‘cost effective’ if their ICER is below the MAICER, and not cost effective otherwise. The probabilities that the addition of TTE is cost-effective at was calculated for MAICERs ranging from £0/QALY to £50,000/QALY. This information was used to create cost-effectiveness acceptability frontiers (CEAFs) for each of the scenarios. CEAFs show the probability of the adoption decision being cost-effective. [13]

## Deterministic sensitivity analyses

Sensitivity analyses were also undertaken on the joint uncertainty in the sensitivity and specificity of TTE in detecting LA ABN. The results for the joint uncertainty for three scenarios are presented in the main article. The remainder of these analyses are presented in the online appendix.

# Results

In these results, the patient population is of 65 year old females with an initial CHADS2 score of 0, and the OAC is either warfarin, rivaroxaban, or dabigatran. Table 3 presents some summary statistics of simulated patient outcomes for strategies that either include or exclude TTE in the decision-making process. Figure 2 show the PSA scatterplots and CEAFs where the OAC is either warfarin (a, b), rivaroxaban (c,d), or dabigatran (e,f). Table 4 shows the mean cost and mean QALY of the baseline (without TTE) and comparator (with TTE) strategy. Results for other patient groups are included in the appendix.

Table 3 indicates that, irrespective of the OAC, using TTE in this way reduces the proportion of deaths caused by stroke, but increases the proportion of deaths caused by bleed. For all OAC scenarios, the number of lifeyears is estimated to be slightly greater when strategy incorporating TTE is used compared to the strategy without TTE, but these differences are relatively small. On average, the scenarios not using TTE are estimated to result in a lower rate of dependent and independent strokes, and a higher rate of major bleeding events, including intracranial haemorrhages (ICHs).

Figure 2 and Table 4 both suggest that the cost-effectiveness of the TTE strategy compared with the no TTE strategy depends on the OAC which would be prescribed should the patient be identified as high risk or suffer a stroke. Where the OAC is warfarin (Table 4a), the ICER comparing the two strategies is almost £40 000 / QALY; where the OAC rivaroxaban (Table 4b), the ICER reduces to around £23 000 /QALY, and where the OAC is dabigatran (Table 4c), the ICER reduces further to around £12 000 / QALY. This relationship is also reflected in the CEAFs of the three scenarios (Figure 2 b, d, and f), as the mean ICER corresponds to the point at which the TTE strategy, indicated by the solid line, becomes the optimal (adoption) decision, and so is first drawn on the figures. Hence, the black line begins furthest to the left of the graph for dabigatran (f) than for rivaroxaban (d), and further to the left for rivaroxaban (d) than for warfarin (b). The PSA scatterplots (a, c, d) all include a proportion of estimates in the north west quadrant, meaning in some of the simulations the without TTE strategy appeared both more costly and less effective than the with TTE strategy; the proportion of estimates in this quadrant is greatest for warfarin (a) than for rivaroxaban (c), and lowest for dabigatran (e). These differences between OAC scenarios are reflected in the height of the solid black lines in the corresponding CEAFs (b, d, f), which indicate the probability that the optimal (adoption) decision is cost-effective at the thresholds indicated by the horizontal axis.

## Deterministic sensitivity analyses

Table 6 shows how the mean ICER estimated depends on sensitivity and specificity of the technology, assuming all other values are held at their mean levels, where the OAC is either a) warfarin, b) rivaroxaban, or c) dabigatran. If TTE had perfect sensitivity and specificity, then the additional cost per QALY is estimated to range from around £1,800/QALY for warfarin (a) to £1,100/QALY for dabigatran (c). However, due to the less than perfect specificity of TTE, estimated to be around 0.35, and the increased number of false positives predicted to be treated as a result of this, the ICERs predicted a lot higher than this, at around £27,000-£59,000/QALY for warfarin (a), £18,000-£29,000 for rivaroxaban (b), and £10,000-£14,000 for dabigatran. As the ICER is a ratio, and the absolute differences in QALYs between strategies with and without TTE are small, the ICERs are shown to be highly sensitive to the values of sensitivity and specificity assumed for some scenarios.

## Overview of results for other scenarios

The results for all 10 scenarios considered are presented in the online appendix. A brief summary, indicating whether the results suggest TTE appears the optimal strategy at MAICERs of £20,000 /QALY or £30,000/QALY, is shown in Table 7. These results suggest that the addition of TTE to help make the decision whether to prescribe an OAC appears more expensive and less effective than not using TTE in younger patients, aged 50 years. In older patients, aged 65 years, the strategy using TTE appears cost-effective and conventional willingness-to-pay thresholds of between £20,000 and £30,000/QALY for dabigatran, and possibly for rivaroxaban. The cost-effectiveness of the strategy appears slightly more favourable for female than for male patients, but the choice of OAC and patient age appear to have much greater influence.

# Discussion

Prior to producing this model, a systematic literature review was conducted to identify, summarise and appraise existing economic studies for evaluating the cost-effectiveness of TTE in patients with AF. This review identified no economic evaluations of the use of TTE in AF patients, so it is believed that this is the first.

The model has a range of limitations and a number of assumptions have been made within the modelling. For example, only the CHADS2 clinical risk prediction tool was used as the baseline strategy. An alternative to this tool is CHA2DS2-VASc, which is considered to be better at distinguishing low risk from very low risk patients, and is the only such tool recommended in the 2012 focused update of the ESC guidelines. [4,14,15] CHA2DS2-VASc was not used in these analyses as the recent NICE recommendations for the use of dabigatran and rivaroxaban both map onto specific CHADS2 risk scores, but not specific CHA2DS2-VASc risk scores. [8,9] The dose of dabigatran was set at 150mg twice daily, rather than allowing some patients to receive a lower dose of 110mg twice daily. The stroke risk associated with patients with LA ABN is assumed not to change as a patient ages; ideally differential rates by age or by the number (and type) of abnormalities would be used but these data were not identified.

Within the study used to derive the sensitivity and specificity of TTE, transoesophageal echocardiography (TOE), was assumed to be a perfect gold standard, and so our model also made this assumption. [6] Using TOE as the gold standard, TTE was estimated to have a very high sensitivity but a specificity of only around 35 %. Within this model, this low specificity corresponds to an increased proportion of ‘false positives’ being included in the patient population mix, and so TTE results in a considerable number of people effectively experiencing increased risks of bleed without the increased benefits in terms of stroke risk reduction estimated in patients with a higher risk of stroke. If TTE were found to be superior to TOE at identifying certain types of LA ABN which expose patients to increased stroke risks, then the true benefits of TTE in improving patient management would be underestimated. The study used to derive sensitivity and specificity was relatively small, of fewer than 400 patients, and also formed the basis of our estimates of the TPHR. [6] This has made the assessment of the benefits of TTE uncertain. A further limitation is that the risk of death unrelated to bleeding or stroke events was taken from lifetables and were not adjusted for the probability of bleeding or stroke mortality. [16]

A key uncertainty is whether there are other benefits that are accrued from a TTE other than identifying some forms of LA ABN. If these exist, and produce even small net QALY gains (> 0.0033) then TTE would be cost effective in all scenarios, assuming a cost of £66 per test. As Table 6b indicates, the structural sensitivity analyses for this scenario indicate that even a diagnostic strategy with a joint sensitivity of one and specificity of zero (i.e. prescribing everyone with the OAC) may be cost effective compared with treating no-one. The implications of this result require further research.

## Implications for Research

For some scenarios the cost effectiveness estimates generated by the model depend heavily on sensitivity and specificity estimates, as well as the true proportion of genuinely high risk (LA ABN positive) patients in this sub-population of apparently ‘low risk’ patients. The model depends strongly on data reported in a single, relatively small study conducted outside of the UK, and so may misrepresent the true values of these parameters. Having a more robust source of evidence for these parameters is likely to significantly improve the accuracy and validity of the mathematical models. The extent to which these cost-effectiveness estimates relate to healthcare in the UK depends on how similar the populations and healthcare systems are, which could be a matter for further research.

Additional research that would improve the validity of the model include identifying any additional net benefits to the management of newly diagnosed AF patient that could result from routine screening with TTE following initial diagnosis.

## Implications for clinical practice

Should TTE be recommended for those patients with CHADS2 scores of zero points, there will be an increase in the number of TTEs performed. This is unlikely to place a great burden on the majority of hospitals who are likely to have staff trained in the use of TTE machines. It is likely that additional bed days are made available due to the reduction in stroke following appropriate management, although there is likely to be an increase in bleed related admissions.

## Conclusion

This paper presented the results of mathematical models which simulated the effects of using TTE to help make the decision whether to prescribe an OAC in a range of patients with AF. If found that when rivaroxaban or dabigatran is the OAC of choice then it appears cost-effective to use TTE in patients aged 65 years; when warfarin is the OAC of choice, then the addition of TTE does not appear cost-effective at standard willingness to pay thresholds of either £20,000/QALY or £30,000/QALY. These results suggest that if considering prescribing a newer OAC, it may be both clinically effective and cost effective to use TTE to help inform the decision.

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Figure 1 Graphical representation of the mathematical model

|  |  |  |  |
| --- | --- | --- | --- |
| **CHADS2 score** | **Prescribe dabigatran** | **Prescribe warfarin** | **Prescribe rivaroxaban** |
| 0 | No | No | No |
| 1 | Yes (age 65 or over) | Yes (or aspirin) | Yes |
| 2 or more | Yes | Yes | Yes |
| **Cohorts simulated** | **Scenarios considered for dabigatran** | **Scenarios considered for warfarin** | **Scenarios considered for rivaroxaban** |
| Males, age 50, CHADS2 score of zero | No † | Yes | Yes |
| Females, age 50, CHADS2 score of zero | No † | Yes | Yes |
| Males, age 65, CHADS2 score of zero | Yes | Yes | Yes |
| Females, age 65, CHADS2 score of zero | Yes | Yes | Yes |
| \* Patient would automatically receive treatment.  † OAC not permitted under NICE guidance | | | |

Table 1 Simplified OAC indications by OAC, and patient cohorts run for each OAC

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Category** | **Description** | **References** |
| **Risks/Probabilities** | Death from other causes | Nonparametric | UK Lifetables. [16] |
| Sensitivity and Specificity of TTE in detecting LA ABN | Jointly estimated from Dirichlet distribution  (FN, TP, TN, FP) =  (5, 87, 83, 159) | Table 2 of Providencia et al 2012 [6] |
| Proportion of patients with LA ABN | Beta(2.5, 22.5) for CHADS2  Beta(0.5, 11.5) for CHA2DS2-VASc  (Both with prior of 0.5 added to both cell counts.) | Table 2 of Providencia et al 2012 [6] |
| Annual stroke risk by CHADS2 score | Simulated from Lognormal distribution | Friberg 2012[17] |
| Annual stroke risk in those with LA ABN | Simulated from Lognormal distribution | Connolly et al 2009 [18] |
| Relative risk (RR) of stroke in patients receiving dabigatran | Indirect comparison simulation approach | Lip et al 2006 for RR of warfarin compared with placebo [19]  Eikelboom et al 2011 for RR of dabigatran compared with warfarin[12] |
| Annual major bleeding risk for patients receiving dabigatran | Stratified by age. Credible interval calculated using simulation approach | Eikelboom et al 2011 [12] |
| Relative risk (RR) of stroke in patients receiving warfarin | RR of warfarin compared with placebo | Lip et al 2006 [19] |
| Annual major bleeding risk for patients receiving warfarin | Stratified by age. Credible interval calculated using simulation approach | Eikelboom et al 2011 [12] |
| Relative risk (RR) of stroke in patients receiving rivaroxaban | Indirect comparison simulation approach | Lip et al 2006 for RR of warfarin compared with placebo [19]  Patel et al 2011 for RR of rivaroxaban compared with warfarin [20] |
| Annual major bleeding risk for patients receiving rivaroxaban |  | Patel et al 2011 [20] |
| Outcome following stroke | Simulation & mapping based approach | Method described in report using results published in Rivero-Arias et al 2010 [21] |
| Outcome following a major bleeding event | Previous estimates | Simpson et al 2010 [22] |
| **Utilities** | Baseline utilities by age and gender | Regression based approach | Ara et al 2010 [23] |
| Utility multiplier following stroke, utility multiplier following major non-fatal intracranial bleed | Simulation & mapping based approach | Method described in report results published in  Rivero-Arias et al 2010 [21] |
| **Costs** | Annual cost of dabigatran | £920.43 | NICE FAD, 2011 [24] |
| Annual cost of rivaroxaban | £767 | London New Drugs Group [25] |
| Annual cost of warfarin | £252 to £259 including monitoring costs | BNF [26] |
| Cost of TTE | £66 | NHS Reference Costs [27] |
| Cost of death due to stroke | £7,019 (95% CrI £6,975 to £7,064) | Sandercock et al 2002 [28] |
| Costs in stroke survivors | Various. Differing according to dependent and independent states. Subdivided into ongoing and continuing costs | NHS Reference Costs [27]  NHS Stroke Strategy Impact Assessment [29]  Unit Costs of Health and Social Care 2010 [30] |
| Costs of fatal bleed | Assumed identical to costs of death due to stroke | |
| Costs of nonfatal bleed | Various  Depends on whether bleed is gastrointestinal or intracranial. If intracranial, depends on severity of resulting disability | NHS Reference Costs [27] |

Table 2 Parameters used in model

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | ***Cause of Death (%)*** | | | ***Average Number of Events*** | | | | | ***Strategy*** | **Life Years** | **Stroke** | **Bleed** | **Other** | **Dependent Strokes** | **Independent Strokes** | **ICH** | **NICH** | | **Without TTE** | 17.132 | 9.0 | 0.9 | 90.2 | 0.087 | 0.192 | 0.007 | 0.052 | | **With TTE** | 17.204 | 8.0 | 1.3 | 90.7 | 0.078 | 0.172 | 0.010 | 0.079 | |
| 1. warfarin |
| |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | ***Cause of Death (%)*** | | | ***Average Number of Events*** | | | | | ***Strategy*** | **Life Years** | **Stroke** | **Bleed** | **Other** | **Dependent Strokes** | **Independent Strokes** | **ICH** | **NICH** | | **Without TTE** | 19.460 | 10.5 | 1.1 | 88.4 | 0.103 | 0.223 | 0.009 | 0.066 | | **With TTE** | 19.554 | 9.4 | 1.6 | 89.0 | 0.093 | 0.201 | 0.012 | 0.096 | |
| 1. rivaroxaban |
| |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | ***Cause of Death (%)*** | | | ***Average Number of Events*** | | | | | ***Strategy*** | **Life Years** | **Stroke** | **Bleed** | **Other** | **Dependent Strokes** | **Independent Strokes** | **ICH** | **NICH** | | **Without TTE** | 19.485 | 10.2 | 1.1 | 88.7 | 0.099 | 0.220 | 0.009 | 0.066 | | **With TTE** | 19.598 | 9.0 | 1.6 | 89.4 | 0.089 | 0.195 | 0.012 | 0.097 | |
| 1. dabigatran |

Table 3 Mean simulated clinical experiences of cohorts of 65 year old females with an initial CHADS2 score of zero, when TTE is either used or not used to inform the decision whether to prescribe either a) warfarin, b) rivaroxaban, or c) dabigatran.

TTE: transthoracic echocardiography; LA ABN- Left atrial abnormality; ICH = intracranial haemorrhage; NICH = non-intracranial haemorrhage

Figure 2 Probabilistic sensitivity analysis (PSA) scatterplots and cost effectiveness acceptability frontiers (CEAFs) of the incremental costs and incremental quality adjusted lifeyears (QALYs) of using transthoracic echocardiography to inform the decision whether to prescribe either warfarin, rivaroxaban, or dabigatran to 65 year old females with atrial fibrillation and an CHADS2 score of zero.

|  |  |
| --- | --- |
| X:\BMJ Echo AF Manuscript\S8\scatter_W_65_F.jpeg | X:\BMJ Echo AF Manuscript\S8\ceaf_W_65_F.jpeg |
| 1. warfarin, scatterplot | 1. warfarin, CEAF |
| X:\EchoAF\R\Figures\R_65_0_F__PSA.jpeg | X:\EchoAF\R\Figures\R_65_0_F__CEAF.jpeg |
| 1. rivaroxaban, scatterplot | 1. rivaroxaban, CEAF |
| X:\EchoAF\R\Figures\D_65_0_F__PSA.jpeg | X:\EchoAF\R\Figures\D_65_0_F__CEAF.jpeg |
| 1. dabigatran, scatterplot | 1. dabigatran, CEAF |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  | | --- | --- | --- | |  | **Mean Cost (£)** | **Mean QALY** | | **Without TTE** | 1 974 | 9.94 | | **With TTE** | 3 106 | 9.97 | | ICER (95% CrIs) | 39 569 (39 374 to 39 839) £/QALY | | |
| 1. warfarin |
| |  |  |  | | --- | --- | --- | |  | **Mean Cost (£)** | **Mean QALY** | | **Without TTE** | 1 955 | 9.95 | | **With TTE** | 3 039 | 9.99 | | ***ICER (95% CrIs)*** | 22 751 (22 681 to 22 844) £/QALY | | |
| 1. rivaroxaban |
| |  |  |  | | --- | --- | --- | |  | **Mean Cost (£)** | **Mean QALY** | | **Without TTE** | 1 942 | 9.95 | | **With TTE** | 2 946 | 10.01 | | ***ICER (95% CrIs)*** | 12 314 (12 290 to 12 348) £/QALY | | |
| 1. dabigatran |

Table 4 Estimated mean costs and mean QALYs of using or not using TTE to make the decision to prescribe either a) warfarin, b) rivaroxaban, or c) dabigatran for 65 year old females with an initial CHADS2 score of zero. ICER: incremental cost effectiveness ratio. CrIs: Credible intervals; calculated using a jacknifing procedure.

Table 6 Illustration of the effect of different levels of sensitivity and specificity on ICER of TTE compared with no TTE in cohorts of female patients aged sixty five, and with an initial CHADS2 score of zero, in making the decision whether to prescribe a) warfarin, b) rivaroxaban, or c) dabigatran. The four cells with sensitivity and specificity values closest to the empirical values are underlined. (Amounts in £1000 / QALY; >99; Over £99,000/QALY; D: Dominated)

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | *Specificity* | | | | | | | | | | |
|  | | **0** | **0.1** | **0.2** | **0.3** | **0.4** | **0.5** | **0.6** | **0.7** | **0.8** | **0.9** | **1** |
| *Sensitivity* | **0** | D | D | D | D | D | D | D | D | D | D | ∞ |
| **0.1** | D | D | D | D | D | D | D | D | D | >99 | 8.1 |
| **0.2** | D | D | D | D | D | D | D | D | >99 | 24.4 | 4.6 |
| **0.3** | D | D | D | D | D | D | D | >99 | 39.9 | 12.9 | 3.4 |
| **0.4** | D | D | D | D | D | D | >99 | 54.7 | 21.0 | 9.0 | 2.8 |
| **0.5** | D | D | D | D | D | >99 | 68.9 | 28.8 | 14.4 | 7.0 | 2.5 |
| **0.6** | D | D | D | D | >99 | 82.4 | 36.5 | 19.8 | 11.1 | 5.8 | 2.3 |
| **0.7** | D | D | D | >99 | 95.4 | 44.1 | 25.1 | 15.2 | 9.1 | 5.0 | 2.1 |
| **0.8** | D | D | >99 | >99 | 51.4 | 30.3 | 19.2 | 12.4 | 7.8 | 4.5 | 2.0 |
| **0.9** | D | >99 | >99 | 58.6 | 35.4 | 23.2 | 15.7 | 10..6 | 6.9 | 4.1 | 1.9 |
| **1** | >99 | >99 | 65.7 | 40.5 | 27.1 | 18.9 | 13.3 | 9.2 | 6.1 | 3.7 | 1.8 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***b)*** | | *Specificity* | | | | | | | | | | |
|  | | **0** | **0.1** | **0.2** | **0.3** | **0.4** | **0.5** | **0.6** | **0.7** | **0.8** | **0.9** | **1** |
| *Sensitivity* | **0** | D | D | D | D | D | D | D | D | D | D | ∞ |
| **0.1** | D | D | D | D | D | D | D | D | D | 77.0 | 7.3 |
| **0.2** | D | D | D | D | D | D | D | D | 65.3 | 17.4 | 4.1 |
| **0.3** | D | D | D | D | D | D | >99 | 61.4 | 23.9 | 10.1 | 3.0 |
| **0.4** | D | D | D | D | D | >99 | 59.5 | 28.4 | 14.8 | 7.3 | 2.4 |
| **0.5** | D | D | D | D | >99 | 58.3 | 31.7 | 18.6 | 10.9 | 5.8 | 2.1 |
| **0.6** | D | D | >99 | >99 | 57.5 | 34.2 | 21.8 | 14.0 | 8.7 | 4.8 | 1.9 |
| **0.7** | D | >99 | >99 | 57.0 | 36.3 | 24.4 | 16.7 | 11.3 | 7.3 | 4.2 | 1.7 |
| **0.8** | >99 | 93.2 | 56.6 | 37.9 | 26.6 | 19.0 | 13.6 | 9.5 | 6.3 | 3.7 | 1.6 |
| **0.9** | 87.0 | 56.2 | 39.3 | 28.5 | 21.1 | 15.6 | 11.5 | 8.2 | 5.6 | 3.4 | 1.5 |
| **1** | 56.0 | 40.4 | 30.1 | 22.9 | 17.5 | 13.3 | 10.0 | 7.3 | 5.0 | 3.1 | 1.5 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***c)*** | | *Specificity* | | | | | | | | | | |
|  | | **0** | **0.1** | **0.2** | **0.3** | **0.4** | **0.5** | **0.6** | **0.7** | **0.8** | **0.9** | **1** |
| *Sensitivity* | **0** | D | D | D | D | D | D | D | D | D | D | ∞ |
| **0.1** | D | D | D | D | D | D | D | D | >99 | 28.3 | 6.2 |
| **0.2** | D | D | D | D | D | >99 | >99 | 46.8 | 23.8 | 11.2 | 3.3 |
| **0.3** | D | D | >99 | >99 | 99.6 | 57.0 | 35.4 | 22.2 | 13.4 | 7.1 | 2.4 |
| **0.4** | >99 | >99 | 97.7 | 63.5 | 43.6 | 30.6 | 21.5 | 14.7 | 9.5 | 5.3 | 1.9 |
| **0.5** | 96.6 | 67.9 | 49.8 | 37.2 | 28.0 | 21.0 | 15.5 | 11.0 | 7.4 | 4.3 | 1.6 |
| **0.6** | 54.5 | 42.5 | 33.5 | 26.4 | 20.7 | 16.1 | 12.2 | 8.9 | 6.1 | 3.6 | 1.4 |
| **0.7** | 38.1 | 31.0 | 25.3 | 20.5 | 16.5 | 13.0 | 10.1 | 7.5 | 5.2 | 3.1 | 1.3 |
| **0.8** | 29.3 | 24.5 | 20.4 | 16.8 | 13.7 | 11.0 | 8.6 | 6.4 | 4.5 | 2.8 | 1.2 |
| **0.9** | 23.9 | 20.2 | 17.1 | 14.3 | 11.8 | 9.5 | 7.5 | 5.7 | 4.0 | 2.5 | 1.1 |
| **1** | 20.1 | 17.3 | 14.7 | 12.4 | 10.3 | 8.4 | 6.7 | 5.1 | 3.6 | 2.3 | 1.1 |

Table 7 Qualitative summary of results of all 10 scenarios. ICERs presented to nearest £1,000/QALY. QALY: Quality Adjusted Lifeyear. ICER: Incremental Cost Effectiveness Ratio. NA: Not applicable. OAC: Oral anticoagulant. TTE: Transthoracic echocardiography. Simple Dominance: TTE strategy is more expensive and less effective than no TTE strategy.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Age | Gender | OAC | ICER of TTE compared with no TTE strategy | TTE optimal | |
| At £20,000 / QALY | At £30,000 / QALY |
| 50 | male | warfarin | NA: Simple dominance | No | No |
| 50 | female | warfarin | NA: Simple dominance | No | No |
| 65 | male | warfarin | £67,000/QALY | No | No |
| 65 | female | warfarin | £40,000/QALY | No | No |
| 50 | male | rivaroxaban | NA: Simple dominance | No | No |
| 50 | female | rivaroxaban | NA: Simple dominance | No | No |
| 65 | male | rivaroxaban | £30,000/QALY | No | Borderline[[1]](#footnote-1) |
| 65 | female | rivaroxaban | £23,000/QALY | No | Yes |
| 65 | male | dabigatran | £15,000/QALY | Yes | Yes |
| 65 | female | dabigatran | £12,000/QALY | Yes | Yes |

# Appendix

## Sensitivity and Specificity tables

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***W\_50*** | | *Specificity* | | | | | | | | | | | | ***0\_M*** | | **0** | **0.1** | **0.2** | **0.3** | **0.4** | **0.5** | **0.6** | **0.7** | **0.8** | **0.9** | **1** | | *Sensitivity* | **0** | D | D | D | D | D | D | D | D | D | D | ∞ | | **0.1** | D | D | D | D | D | D | D | D | D | D | 8.4 | | **0.2** | D | D | D | D | D | D | D | D | D | D | 5.7 | | **0.3** | D | D | D | D | D | D | D | D | D | 70.7 | 4.9 | | **0.4** | D | D | D | D | D | D | D | D | D | 26.2 | 4.4 | | **0.5** | D | D | D | D | D | D | D | D | >99 | 17.1 | 4.2 | | **0.6** | D | D | D | D | D | D | D | D | 65.6 | 13.1 | 4.0 | | **0.7** | D | D | D | D | D | D | D | D | 35.0 | 10.9 | 3.8 | | **0.8** | D | D | D | D | D | D | D | >99 | 24.5 | 9.5 | 3.8 | | **0.9** | D | D | D | D | D | D | D | 63.9 | 19.2 | 8.5 | 3.7 | | **1** | D | D | D | D | D | D | >99 | 40.2 | 16.0 | 7.8 | 3.6 | |
| 1. W\_50\_0\_M |
| |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***W\_65*** | | *Specificity* | | | | | | | | | | | | ***0\_M*** | | **0** | **0.1** | **0.2** | **0.3** | **0.4** | **0.5** | **0.6** | **0.7** | **0.8** | **0.9** | **1** | | *Sensitivity* | **0** | D | D | D | D | D | D | D | D | D | D | ∞ | | **0.1** | D | D | D | D | D | D | D | D | D | D | 8.9 | | **0.2** | D | D | D | D | D | D | D | D | D | 29.8 | 4.9 | | **0.3** | D | D | D | D | D | D | D | D | 62.8 | 13.9 | 3.6 | | **0.4** | D | D | D | D | D | D | D | >99 | 25.0 | 9.3 | 2.9 | | **0.5** | D | D | D | D | D | D | >99 | 38.8 | 15.9 | 7.1 | 2.5 | | **0.6** | D | D | D | D | D | >99 | 56.6 | 23.4 | 11.8 | 5.8 | 2.3 | | **0.7** | D | D | D | D | D | 80.4 | 32.1 | 16.9 | 9.4 | 5.0 | 2.1 | | **0.8** | D | D | D | D | >99 | 42.3 | 22.6 | 13.3 | 7.9 | 4.4 | 1.9 | | **0.9** | D | D | D | >99 | 54.5 | 28.9 | 17.5 | 11.0 | 6.9 | 4.0 | 1.8 | | **1** | D | D | >99 | 69.3 | 36.1 | 22.1 | 14.4 | 9.5 | 6.1 | 3.6 | 1.7 |  1. W\_65\_0\_M |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***W\_65*** | | Specificity | | | | | | | | | | | | ***0\_F*** | | **0** | **0.1** | **0.2** | **0.3** | **0.4** | **0.5** | **0.6** | **0.7** | **0.8** | **0.9** | **1** | | *Sensitivity* | **0** | D | D | D | D | D | D | D | D | D | D | ∞ | | **0.1** | D | D | D | D | D | D | D | D | D | >99 | 8.1 | | **0.2** | D | D | D | D | D | D | D | D | >99 | 24.4 | 4.6 | | **0.3** | D | D | D | D | D | D | D | >99 | 39.8 | 12.9 | 3.4 | | **0.4** | D | D | D | D | D | D | >99 | 54.5 | 21.0 | 9.0 | 2.8 | | **0.5** | D | D | D | D | D | >99 | 68.6 | 28.8 | 14.4 | 7.0 | 2.5 | | **0.6** | D | D | D | D | >99 | 82.0 | 36.5 | 19.8 | 11.1 | 5.8 | 2.3 | | **0.7** | D | D | D | >99 | 94.7 | 44.1 | 25.1 | 15.2 | 9.1 | 5.0 | 2.1 | | **0.8** | D | D | >99 | >99 | 51.4 | 30.3 | 19.2 | 12.4 | 7.8 | 4.5 | 2.0 | | **0.9** | D | >99 | >99 | 58.4 | 35.4 | 23.2 | 15.7 | 10.6 | 6.9 | 4.1 | 1.9 | | **1** | >99 | >99 | 65.4 | 40.4 | 27.1 | 18.9 | 13.3 | 9.2 | 6.1 | 3.7 | 1.8 | |
| 1. W\_65\_0\_F |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***R\_50*** | | *Sensitivity* | | | | | | | | | | | | ***0\_M*** | | **0** | **0.1** | **0.2** | **0.3** | **0.4** | **0.5** | **0.6** | **0.7** | **0.8** | **0.9** | **1** | | *Specificity* | **0** | D | D | D | D | D | D | D | D | D | D | ∞ | | **0.1** | D | D | D | D | D | D | D | D | D | D | 7.5 | | **0.2** | D | D | D | D | D | D | D | D | D | D | 5.1 | | **0.3** | D | D | D | D | D | D | D | D | D | 38.2 | 4.3 | | **0.4** | D | D | D | D | D | D | D | D | D | 19.0 | 3.9 | | **0.5** | D | D | D | D | D | D | D | D | 82.0 | 13.3 | 3.6 | | **0.6** | D | D | D | D | D | D | D | D | 35.4 | 10.5 | 3.5 | | **0.7** | D | D | D | D | D | D | D | >99 | 23.2 | 8.9 | 3.3 | | **0.8** | D | D | D | D | D | D | D | 54.8 | 17.7 | 7.8 | 3.2 | | **0.9** | D | D | D | D | D | D | >99 | 34.4 | 14.5 | 7.1 | 3.2 | | **1** | D | D | D | D | D | D | 78.5 | 25.5 | 12.4 | 6.5 | 3.1 | |
| 1. R\_50\_0\_M |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***R\_50*** | | *Sensitivity* | | | | | | | | | | | | ***0\_F*** | | **0** | **0.1** | **0.2** | **0.3** | **0.4** | **0.5** | **0.6** | **0.7** | **0.8** | **0.9** | **1** | | *Specificity* | **0** | D | D | D | D | D | D | D | D | D | D | ∞ | | **0.1** | D | D | D | D | D | D | D | D | D | D | 7.5 | | **0.2** | D | D | D | D | D | D | D | D | D | D | 5.2 | | **0.3** | D | D | D | D | D | D | D | D | D | 35.2 | 4.4 | | **0.4** | D | D | D | D | D | D | D | D | D | 19.1 | 4.0 | | **0.5** | D | D | D | D | D | D | D | D | 63.0 | 13.7 | 3.8 | | **0.6** | D | D | D | D | D | D | D | D | 32.9 | 11.0 | 3.7 | | **0.7** | D | D | D | D | D | D | D | 90.7 | 22.9 | 9.4 | 3.6 | | **0.8** | D | D | D | D | D | D | D | 46.8 | 17.9 | 8.3 | 3.5 | | **0.9** | D | D | D | D | D | D | >99 | 32.2 | 14.9 | 7.5 | 3.4 | | **1** | D | D | D | D | D | D | 60.7 | 24.8 | 12.9 | 6.9 | 3.4 | |
| 1. R\_50\_0\_F |
| |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***R\_65*** | | *Sensitivity* | | | | | | | | | | | | ***0\_M*** | | **0** | **0.1** | **0.2** | **0.3** | **0.4** | **0.5** | **0.6** | **0.7** | **0.8** | **0.9** | **1** | | *Specificity* | **0** | D | D | D | D | D | D | D | D | D | D | ∞ | | **0.1** | D | D | D | D | D | D | D | D | D | >99 | 8.0 | | **0.2** | D | D | D | D | D | D | D | D | >99 | 20.4 | 4.4 | | **0.3** | D | D | D | D | D | D | D | >99 | 31.5 | 10.8 | 3.1 | | **0.4** | D | D | D | D | D | D | >99 | 41.5 | 16.9 | 7.5 | 2.5 | | **0.5** | D | D | D | D | D | >99 | 50.7 | 22.7 | 11.7 | 5.8 | 2.2 | | **0.6** | D | D | D | D | >99 | 59.1 | 28.2 | 15.7 | 9.0 | 4.8 | 1.9 | | **0.7** | D | D | D | >99 | 66.7 | 33.4 | 19.6 | 12.1 | 7.4 | 4.1 | 1.7 | | **0.8** | D | D | >99 | 73.8 | 38.4 | 23.4 | 15.2 | 9.9 | 6.3 | 3.6 | 1.6 | | **0.9** | D | >99 | 80.3 | 43.2 | 27.1 | 18.1 | 12.4 | 8.4 | 5.5 | 3.3 | 1.5 | | **1** | >99 | 86.3 | 47.7 | 30.6 | 21.0 | 14.8 | 10.5 | 7.3 | 4.9 | 3.0 | 1.4 | |
| 1. R\_65\_0\_M |
| |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***R\_65*** | | *Sensitivity* | | | | | | | | | | | | ***0\_F*** | | **0** | **0.1** | **0.2** | **0.3** | **0.4** | **0.5** | **0.6** | **0.7** | **0.8** | **0.9** | **1** | | *Specificity* | **0** | D | D | D | D | D | D | D | D | D | D | ∞ | | **0.1** | D | D | D | D | D | D | D | D | D | 77.0 | 7.3 | | **0.2** | D | D | D | D | D | D | D | D | 65.3 | 17.4 | 4.1 | | **0.3** | D | D | D | D | D | D | >99 | 61.4 | 23.9 | 10.1 | 3.0 | | **0.4** | D | D | D | D | D | >99 | 59.5 | 28.4 | 14.8 | 7.3 | 2.4 | | **0.5** | D | D | D | D | >99 | 58.3 | 31.7 | 18.6 | 10.9 | 5.8 | 2.1 | | **0.6** | D | D | >99 | >99 | 57.5 | 34.2 | 21.8 | 14.0 | 8.7 | 4.8 | 1.9 | | **0.7** | D | >99 | >99 | 57.0 | 36.3 | 24.4 | 16.7 | 11.3 | 7.3 | 4.2 | 1.7 | | **0.8** | >99 | 93.2 | 56.6 | 37.9 | 26.6 | 19.0 | 13.6 | 9.5 | 6.3 | 3.7 | 1.6 | | **0.9** | 87.0 | 56.2 | 39.3 | 28.5 | 21.1 | 15.6 | 11.5 | 8.2 | 5.6 | 3.4 | 1.5 | | **1** | 56.0 | 40.4 | 30.1 | 22.9 | 17.5 | 13.3 | 10.0 | 7.3 | 5.0 | 3.1 | 1.5 | |
| 1. R\_65\_0\_F |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***D\_65*** | | *Sensitivity* | | | | | | | | | | | | ***0\_M*** | | **0** | **0.1** | **0.2** | **0.3** | **0.4** | **0.5** | **0.6** | **0.7** | **0.8** | **0.9** | **1** | | *Specificity* | **0** | D | D | D | D | D | D | D | D | D | D | ∞ | | **0.1** | D | D | D | D | D | D | D | D | D | 44.1 | 6.8 | | **0.2** | D | D | D | D | D | D | D | >99 | 36.0 | 12.8 | 3.6 | | **0.3** | D | D | D | D | D | >99 | 84.7 | 33.4 | 16.2 | 7.6 | 2.5 | | **0.4** | D | D | D | D | >99 | 62.0 | 32.0 | 18.3 | 10.5 | 5.5 | 1.9 | | **0.5** | D | D | >99 | >99 | 52.3 | 31.2 | 19.8 | 12.7 | 7.9 | 4.3 | 1.6 | | **0.6** | >99 | >99 | 79.3 | 46.9 | 30.7 | 20.9 | 14.4 | 9.8 | 6.3 | 3.6 | 1.4 | | **0.7** | >99 | 66.5 | 43.5 | 30.3 | 21.8 | 15.8 | 11.4 | 8.0 | 5.3 | 3.1 | 1.2 | | **0.8** | 58.8 | 41.1 | 30.0 | 22.4 | 16.9 | 12.7 | 9.4 | 6.7 | 4.5 | 2.7 | 1.1 | | **0.9** | 39.3 | 29.8 | 22.9 | 17.8 | 13.8 | 10.6 | 8.0 | 5.8 | 4.0 | 2.4 | 1.0 | | **1** | 29.6 | 23.4 | 18.6 | 14.8 | 11.7 | 9.2 | 7.0 | 5.2 | 3.6 | 2.2 | 1.0 | |
| 1. D\_65\_0\_M |
| |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***D\_65*** | | *Sensitivity* | | | | | | | | | | | | ***0\_F*** | | **0** | **0.1** | **0.2** | **0.3** | **0.4** | **0.5** | **0.6** | **0.7** | **0.8** | **0.9** | **1** | | *Specificity* | **0** | D | D | D | D | D | D | D | D | D | D | ∞ | | **0.1** | D | D | D | D | D | D | D | D | >99 | 28.3 | 6.2 | | **0.2** | D | D | D | D | D | >99 | >99 | 46.8 | 23.8 | 11.2 | 3.3 | | **0.3** | D | D | >99 | >99 | 99.6 | 57.0 | 35.4 | 22.2 | 13.4 | 7.1 | 2.4 | | **0.4** | >99 | >99 | 97.7 | 63.5 | 43.6 | 30.6 | 21.5 | 14.7 | 9.5 | 5.3 | 1.9 | | **0.5** | 96.6 | 67.9 | 49.8 | 37.2 | 28.0 | 21.0 | 15.5 | 11.0 | 7.4 | 4.3 | 1.6 | | **0.6** | 54.5 | 42.5 | 33.5 | 26.4 | 20.7 | 16.1 | 12.2 | 8.9 | 6.1 | 3.6 | 1.4 | | **0.7** | 38.1 | 31.0 | 25.3 | 20.5 | 16.5 | 13.0 | 10.1 | 7.5 | 5.2 | 3.1 | 1.3 | | **0.8** | 29.3 | 24.5 | 20.4 | 16.8 | 13.7 | 11.0 | 8.6 | 6.4 | 4.5 | 2.8 | 1.2 | | **0.9** | 23.9 | 20.2 | 17.1 | 14.3 | 11.8 | 9.5 | 7.5 | 5.7 | 4.0 | 2.5 | 1.1 | | **1** | 20.1 | 17.3 | 14.7 | 12.4 | 10.3 | 8.4 | 6.7 | 5.1 | 3.6 | 2.3 | 1.1 | |
| 1. D\_65\_0\_F |

# Fifty year old males, initial CHADS2 score of 0, treated with Warfarin

## Results

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | ***Cause of Death (%)*** | | | ***Average Number of Events*** | | | | |
| ***Strategy*** | **Life Years** | **Stroke** | **Bleed** | **Other** | **Dependent Strokes** | **Independent Strokes** | | **ICH** | **NICH** |
| **Without TTE** | 28.840 | 11.7 | 1.3 | 87.1 | 0.120 | 0.242 | | 0.010 | 0.075 |
| **With TTE** | 28.928 | 10.8 | 1.8 | 87.4 | 0.111 | 0.223 | | 0.014 | 0.112 |
| X:\EchoAF\R\Figures\W_50_0_M__PSA.jpeg | | | | | | | | X:\EchoAF\R\Figures\W_50_0_M__CEAF.jpeg | | | |
| a ) Scatterplot of difference in costs (£) against differences in QALYs | | | | | | | | b) Cost-effectiveness Acceptability Frontier | | | |
| |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***W\_50\_0\_M*** | **Mean Cost** | **Mean QALY** |  |  | **Mean** | **Jackknifed 95% Credible Intervals** | | | | | | | *No TTE* | £ 2,459 | 13.60 |  | ***ICER (£/QALY)*** | -£ 26,489 | -£ 26,552 | to | | -£ 26,408 | |  | | *TTE* | £ 4,712 | 13.51 |  | *Interpretation:* | *Dominated* | | |  | |  |  | | | | | | | | | | | | |
| c) Mean costs, QALYs and ICERs | | | | | | | | | | | |

# Fifty year old females with initial CHADS2 score of 0, treated with Warfarin

## Results

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | ***Cause of Death (%)*** | | | ***Average Number of Events*** | | | |
| ***Strategy*** | **Life Years** | **Stroke** | **Bleed** | **Other** | **Dependent Strokes** | **Independent Strokes** | **ICH** | **NICH** |
| **Without TTE** | 31.633 | 13.5 | 1.6 | 84.9 | 0.139 | 0.278 | 0.012 | 0.091 |
| **With TTE** | 31.734 | 12.6 | 2.1 | 85.2 | 0.130 | 0.259 | 0.017 | 0.130 |

|  |  |
| --- | --- |
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| a ) Scatterplot of difference in costs (£) against differences in QALYs | b) Cost-effectiveness Acceptability Frontier |
| |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***W\_50\_0\_F*** | **Mean Cost** | **Mean QALY** |  |  | **Mean** | **Jackknifed 95% Credible Intervals** | | | | | | | *No TTE* | £ 2,815 | 14.27 |  | ***ICER (£/QALY)*** | -£ 34,078 | -£ 34,175 | to | | -£ 33,952 | |  | | *TTE* | £ 5,405 | 14.19 |  | *Interpretation:* | *Dominated* | | |  | |  |  | | |
| c) Mean costs, QALYs and ICERs | |

# Sixty five year old males with initial CHADS2 score of 0, treated with Warfarin

## Results

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | ***Cause of Death (%)*** | | | ***Average Number of Events*** | | | |
| ***Strategy*** | **Life Years** | **Stroke** | **Bleed** | **Other** | **Dependent Strokes** | **Independent Strokes** | **ICH** | **NICH** |
| **Without TTE** | 17.131 | 9.0 | 0.9 | 90.2 | 0.087 | 0.192 | 0.007 | 0.052 |
| **With TTE** | 17.204 | 8.0 | 1.3 | 90.7 | 0.078 | 0.172 | 0.010 | 0.079 |

|  |  |
| --- | --- |
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| a ) Scatterplot of difference in costs (£) against differences in QALYs | b) Cost-effectiveness Acceptability Frontier |
| |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***W\_65\_0\_M*** | **Mean Cost** | **Mean QALY** |  |  | **Mean** | **Jackknifed 95% Credible Intervals** | | | | | | *No TTE* | £ 1,527 | 9.12 |  | ***ICER (£/QALY)*** | £ 66,793 | £ 66,217 | to | £ 67,599 | |  | | *TTE* | £ 2,467 | 9.13 |  | *Interpretation:* | *Neither dominated nor dominating* | | | |  |  | | |
| c) Mean costs, QALYs and ICERs | |

# Sixty five year old females with initial CHADS2 score of 0, treated with Warfarin

## Results

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | ***Cause of Death (%)*** | | | ***Average Number of Events*** | | | |
| ***Strategy*** | **Life Years** | **Stroke** | **Bleed** | **Other** | **Dependent Strokes** | **Independent Strokes** | **ICH** | **NICH** |
| **Without TTE** | 19.447 | 10.6 | 1.1 | 88.3 | 0.105 | 0.225 | 0.009 | 0.065 |
| **With TTE** | 19.531 | 9.6 | 1.6 | 88.8 | 0.096 | 0.205 | 0.012 | 0.095 |

|  |  |
| --- | --- |
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| a ) Scatterplot of difference in costs (£) against differences in QALYs | b) Cost-effectiveness Acceptability Frontier |
| |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***W\_65\_0\_F*** | **Mean Cost** | **Mean QALY** |  |  | **Mean** | **Jackknifed 95% Credible Intervals** | | | | | | *No TTE* | £ 1,974 | 9.94 |  | ***ICER (£/QALY)*** | £ 39,485 | £ 39,291 | to | £ 39,754 | |  | | *TTE* | £ 3,106 | 9.97 |  | *Interpretation:* | *Neither dominated nor dominating* | | | |  |  | | |
| c) Mean costs, QALYs and ICERs | |

# Fifty year old males with initial CHADS2 score of 0, treated with Rivaroxaban

## Results

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | ***Cause of Death (%)*** | | | ***Average Number of Events*** | | | |
| ***Strategy*** | **Life Years** | **Stroke** | **Bleed** | **Other** | **Dependent Strokes** | **Independent Strokes** | **ICH** | **NICH** |
| **Without TTE** | 28.861 | 11.5 | 1.3 | 87.2 | 0.117 | 0.239 | 0.010 | 0.075 |
| **With TTE** | 28.963 | 10.5 | 1.8 | 87.6 | 0.108 | 0.219 | 0.014 | 0.113 |

|  |  |
| --- | --- |
| X:\EchoAF\R\Figures\R_50_0_M__PSA.jpeg | X:\EchoAF\R\Figures\R_50_0_M__CEAF.jpeg |
| a ) Scatterplot of difference in costs (£) against differences in QALYs | b) Cost-effectiveness Acceptability Frontier |
| |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***R\_50\_0\_M*** | **Mean Cost** | **Mean QALY** |  |  | **Mean** | **Jackknifed 95% Credible Intervals** | | | | | | | *No TTE* | £ 2,449 | 13.61 |  | ***ICER (£/QALY)*** | -£ 34,060 | -£ 34,170 | to | | -£ 33,910 | |  | | *TTE* | £ 4,614 | 13.54 |  | *Interpretation:* | *Dominated* | | |  | |  |  | | |
| c) Mean costs, QALYs and ICERs | |

# Fifty year old females with initial CHADS2 score of 0, treated with rivaroxaban

## Results

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | ***Cause of Death (%)*** | | | ***Average Number of Events*** | | | |
| ***Strategy*** | **Life Years** | **Stroke** | **Bleed** | **Other** | **Dependent Strokes** | **Independent Strokes** | **ICH** | **NICH** |
| **Without TTE** | 31.657 | 13.3 | 1.6 | 85.1 | 0.136 | 0.275 | 0.012 | 0.091 |
| **With TTE** | 31.772 | 12.4 | 2.1 | 85.5 | 0.127 | 0.255 | 0.017 | 0.130 |

|  |  |
| --- | --- |
| X:\EchoAF\R\Figures\R_50_0_F__PSA.jpeg | X:\EchoAF\R\Figures\R_50_0_F__CEAF.jpeg |
| a ) Scatterplot of difference in costs (£) against differences in QALYs | b) Cost-effectiveness Acceptability Frontier |
| |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***R\_50\_0\_F*** | **Mean Cost** | **Mean QALY** |  |  | **Mean** | **Jackknifed 95% Credible Intervals** | | | | | | | *No TTE* | £ 2,779 | 14.27 |  | ***ICER (£/QALY)*** | -£ 47,535 | -£ 47,773 | to | | -£ 47,271 | |  | | *TTE* | £ 5,315 | 14.22 |  | *Interpretation:* | *Dominated* | | |  | |  |  | | |
| c) Mean costs, QALYs and ICERs | |

# Sixty five year old males with initial CHADS2 score of 0, treated with rivaroxaban

## Results

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | ***Cause of Death (%)*** | | | ***Average Number of Events*** | | | |
| ***Strategy*** | **Life Years** | **Stroke** | **Bleed** | **Other** | **Dependent Strokes** | **Independent Strokes** | **ICH** | **NICH** |
| **Without TTE** | 17.141 | 8.8 | 0.9 | 90.3 | 0.085 | 0.190 | 0.007 | 0.052 |
| **With TTE** | 17.221 | 7.8 | 1.3 | 90.9 | 0.076 | 0.169 | 0.010 | 0.080 |

|  |  |
| --- | --- |
| X:\EchoAF\R\Figures\R_65_0_M__PSA.jpeg | X:\EchoAF\R\Figures\R_65_0_M__CEAF.jpeg |
| a ) Scatterplot of difference in costs (£) against differences in QALYs | b) Cost-effectiveness Acceptability Frontier |
| |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***R\_65\_0\_M*** | **Mean Cost** | **Mean QALY** |  |  | **Mean** | **Jackknifed 95% Credible Intervals** | | | | | | *No TTE* | £ 1,510 | 9.12 |  | ***ICER (£/QALY)*** | £ 30,310 | £ 30,179 | to | £ 30,487 | |  | | *TTE* | £ 2,393 | 9.15 |  | *Interpretation:* | *Neither dominated nor dominating* | | | |  |  | | |
| c) Mean costs, QALYs and ICERs | |

# Sixty five year old females with initial CHADS2 score of 0, treated with rivaroxaban

## Results

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | ***Cause of Death (%)*** | | | ***Average Number of Events*** | | | |
| ***Strategy*** | **Life Years** | **Stroke** | **Bleed** | **Other** | **Dependent Strokes** | **Independent Strokes** | **ICH** | **NICH** |
| **Without TTE** | 19.460 | 10.5 | 1.1 | 88.4 | 0.103 | 0.223 | 0.009 | 0.066 |
| **With TTE** | 19.554 | 9.4 | 1.6 | 89.0 | 0.093 | 0.201 | 0.012 | 0.096 |

|  |  |
| --- | --- |
| X:\EchoAF\R\Figures\R_65_0_F__PSA.jpeg | X:\EchoAF\R\Figures\R_65_0_F__CEAF.jpeg |
| a ) Scatterplot of difference in costs (£) against differences in QALYs | b) Cost-effectiveness Acceptability Frontier |
| |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***R\_65\_0\_F*** | **Mean Cost** | **Mean QALY** |  |  | **Mean** | **Jackknifed 95% Credible Intervals** | | | | | | *No TTE* | £ 1,955 | 9.95 |  | ***ICER (£/QALY)*** | £ 22,751 | £ 22,681 | to | £ 22,844 | |  | | *TTE* | £ 3,039 | 9.99 |  | *Interpretation:* | *Neither dominated nor dominating* | | | |  | | | |
| c) Mean costs, QALYs and ICERs | |

# Sixty five year old males with initial CHADS2 score of 0, treated with dabigatran

## Results

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | ***Cause of Death (%)*** | | | ***Average Number of Events*** | | | |
| ***Strategy*** | **Life Years** | **Stroke** | **Bleed** | **Other** | **Dependent Strokes** | **Independent Strokes** | **ICH** | **NICH** |
| **Without TTE** | 17.158 | 8.6 | 0.9 | 90.5 | 0.081 | 0.188 | 0.007 | 0.053 |
| **With TTE** | 17.251 | 7.5 | 1.3 | 91.2 | 0.072 | 0.163 | 0.010 | 0.081 |

|  |  |
| --- | --- |
| X:\EchoAF\R\Figures\D_65_0_M__PSA.jpeg | X:\EchoAF\R\Figures\D_65_0_M__CEAF.jpeg |
| a ) Scatterplot of difference in costs (£) against differences in QALYs | b) Cost-effectiveness Acceptability Frontier |
| |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***D\_65\_0\_M*** | **Mean Cost** | **Mean QALY** |  |  | **Mean** | **Jackknifed 95% Credible Intervals** | | | | | | *No TTE* | £ 1,489 | 9.13 |  | ***ICER (£/QALY)*** | £ 14,728 | £ 14,693 | to | £ 14,782 | |  | | *TTE* | £ 2,321 | 9.18 |  | *Interpretation:* | *Neither dominated nor dominating* | | | |  | | | |
| c) Mean costs, QALYs and ICERs | |

# Sixty five year old females with initial CHADS2 score of 0, treated with dabigatran

## Results

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | ***Cause of Death (%)*** | | | ***Average Number of Events*** | | | |
| ***Strategy*** | **Life Years** | **Stroke** | **Bleed** | **Other** | **Dependent Strokes** | **Independent Strokes** | **ICH** | **NICH** |
| **Without TTE** | 19.485 | 10.2 | 1.1 | 88.7 | 0.099 | 0.220 | 0.009 | 0.066 |
| **With TTE** | 19.598 | 9.0 | 1.6 | 89.4 | 0.089 | 0.195 | 0.012 | 0.097 |

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| --- | --- |
| X:\EchoAF\R\Figures\D_65_0_F__PSA.jpeg | X:\EchoAF\R\Figures\D_65_0_F__CEAF.jpeg |
| a ) Scatterplot of difference in costs (£) against differences in QALYs | b) Cost-effectiveness Acceptability Frontier |
| |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***D\_65\_0\_F*** | **Mean Cost** | **Mean QALY** |  |  | **Mean** | **Jackknifed 95% Credible Intervals** | | | | | | *No TTE* | £ 1,942 | 9.95 |  | ***ICER (£/QALY)*** | £ 12,314 | £ 12,290 | to | £ 12,348 | |  | | *TTE* | £ 2,946 | 10.01 |  | *Interpretation:* | *Neither dominated nor dominating* | | | |  |  | | |
| c) Mean costs, QALYs and ICERs | |

1. Precise ICER is £30,310/QALY, so the No TTE option is still optimal at £30,000/QALY. [↑](#footnote-ref-1)