neck among Korean is unknown and cost-analysis with regard to EndoAnchors has not been established.

METHODS:

To figure out the population size of AAA patients with hostile neck anatomy, retrospective medical chart review was conducted from four major medical centers. Hostile proximal aortic neck was defined as any or all of neck length 28 mm, infrarenal neck angulation >60°, ≥50 percent of circumferential thrombus, ≥50 percent of calcified neck, and conical neck. Cost-analysis on EndoAnchor use for treatment purpose was conducted based on Korean National Health Insurance Claims dataset (HIRA-NIS 2015).

RESULTS:

Two-hundred and ten patients' anatomic data treated with EVAR were included; 130 (61.9 percent) patients met the criteria for a hostile aortic neck and 32 (15.2 percent) patients had multiple hostile anatomy parameters. Endograft migration was reported in four (1.9 percent) patients and intra or post-op type I endoleak was reported in 21 (10.0 percent) patients. Based on 1-year claims data, 1,607 patients were treated with EVAR in 2015 and the annual average medical costs for open repair were USD 16,151. Given the patients with type I endoleak or endograft migration needs open repair if not treated with EndoAnchors, the estimated annual costs for patients treated with EndoAnchor were USD 2,234,321 and those for patients without EndoAnchor were USD 2,595,508, therefore USD 361,187 can be saved annually.

CONCLUSIONS:

The population size with hostile aortic neck in Korea was comparable with those in western countries. Economically, EndoAnchor is a cost-saving treatment for type I endoleak and migration after EVAR from Korean payer.

PD85 Testing Search Filters To Retrieve Economic Evaluations In Embase

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INTRODUCTION:

Health technology assessments (HTAs) are increasingly used by Norwegian health authorities as the evidence base when prioritizing which health care services to offer. HTAs typically consist of a systematic review of the effects and safety of two or more health care interventions, and an economic evaluation of the interventions, based on systematic literature searches in bibliographic databases. Objective: To identify the best performing of seven search filters to retrieve health economic evaluations used to inform HTAs, by comparing the cost-effectiveness analysis (CEA) filter to six published filters in Ovid Embase, and achieve a sensitivity of at least 0.90 with a precision of 0.10, and specificity of at least 0.95.

METHODS:

In this filter validation study, the included filters' performances were compared against a gold standard of economic evaluations published in 2008–2013 (n = 2,248) from the National Health Service Economic Evaluation Database (NHS EED), and the corresponding records (n = 2,198) in the current version of Ovid Embase.

RESULTS:

The CEA filter had a sensitivity of 0.899 and precision of 0.029. One filter had a sensitivity of 0.880 and a precision of 0.075, which was closest to the objective. The filter with lowest sensitivity (0.702) had a precision of 0.141.

CONCLUSIONS:

Developing search filters for identifying health economic evaluations, with a good balance between sensitivity and precision, is possible but challenging. Researchers should agree on acceptable levels of performance before concluding on which search filter to use.

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