Cost-Effectiveness of Clopidogrel-Aspirin Versus Aspirin Alone for Acute Transient Ischemic Attack and Minor Stroke

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Background—Treatment with the combination of clopidogrel and aspirin taken soon after a transient ischemic attack (TIA) or minor stroke was shown to reduce the 90-day risk of stroke in a large trial in China, but the cost-effectiveness is unknown. This study sought to estimate the cost-effectiveness of the clopidogrel-aspirin regimen for acute TIA or minor stroke.

Methods and Results—A Markov model was created to determine the cost-effectiveness of treatment of acute TIA or minor stroke patients with clopidogrel-aspirin compared with aspirin alone. Inputs for the model were obtained from clinical trial data, claims databases, and the published literature. The main outcome measure was cost per quality-adjusted life-years (QALYs) gained. One-way and multivariable probabilistic sensitivity analyses were performed to test the robustness of the findings. Compared with aspirin alone, clopidogrel-aspirin resulted in a lifetime gain of 0.037 QALYs at an additional cost of CNY 1250 (US$ 192), yielding an incremental cost-effectiveness ratio of CNY 33 800 (US$ 5200) per QALY gained. Probabilistic sensitivity analysis showed that clopidogrel-aspirin therapy was more cost-effective in 95.7% of the simulations at a willingness-to-pay threshold recommended by the World Health Organization of CNY 105 000 (US$ 16 200) per QALY.

Conclusions—Early 90-day clopidogrel-aspirin regimen for acute TIA or minor stroke is highly cost-effective in China. Although clopidogrel is generic, Plavix is brand in China. If Plavix were generic, treatment with clopidogrel-aspirin would have been cost saving. (J Am Heart Assoc. 2014;3:e000912 doi: 10.1161/JAHA.114.000912)

Key Words: clopidogrel • cost-effectiveness • quality-adjusted life-year • stroke

The early (90-day) risk of recurrence of stroke and other vascular events following index transient ischemic attack (TIA) and minor ischemic stroke is very high, even in patients treated with aspirin, the current standard of care.1–3 Treatment with the combination of clopidogrel and aspirin taken soon after a TIA or minor stroke was found to decrease the 90-day risk of stroke (hazard ratio 0.68, 95% CI 0.57 to 0.81, P<0.001) but did not increase the risk of hemorrhage compared with aspirin alone in the CHANCE stroke trial (Clopidogrel in High-risk patients with Acute Non-disabling Cerebrovascular Events Trial).4 Although the clopidogrel-aspirin regimen is a reasonable early management for TIA and minor ischemic stroke, the extent of its adoption and use in clinical practice will depend—to some extent—on its economic practicality. However, the cost-effectiveness, which is very important for patients, clinicians, and policy-makers, has not been evaluated. In this analysis, we sought to determine the cost-effectiveness of adding clopidogrel to aspirin in patients with acute TIA or minor stroke.

Methods

Model Overview

We adhered to the recommendations of the Panel on Cost-effectiveness in Health and Medicine.5 Markov models are generally used to estimate the long term costs and outcomes associated with a disease and a particular healthcare intervention, in which the disease is divided into distinct states and transits between these states over a discrete time period under assigned transitions probabilities.6
A Markov model was developed (Figure 1) to simulate the cost-effectiveness of two antiplatelet treatment strategies for high-risk patients with acute minor stroke or TIA: (1) clopidogrel-aspirin strategy; a 300-mg loading dose of clopidogrel followed by 75 mg clopidogrel per day on days 2 to 90 plus aspirin 75 to 300 mg on day 1 followed by 75 mg/day on days 2 to 21 or (2) aspirin-alone strategy: aspirin 75 to 300 mg on day 1 followed by 75 mg/day on days 2 to 90. The base-case was a cohort of 100,000 patients (33% female), with mean age of 63 years at the time of acute ischemic minor stroke or TIA, which is the sex distribution and mean age of the patients who were enrolled in the CHANCE trial (Clopidogrel in High-risk patients with Acute Non-disabling Cerebrovascular Events Trial). Patients in the two treatment arms entered the model at the Markov health state of minor or no disability and transited to other health states (ischemic stroke or intracranial hemorrhage with minor or no disability, moderate disability, severe disability, myocardial infarction, extracranial hemorrhage, and dead) in the next cycle. Death (by stroke or other causes) was the only absorbing state after which the patient was excluded from the model. Total direct medical costs and quality-adjusted life-years (QALYs) gained with each alternative were estimated for each health state at 90 days from onset of TIA or minor stroke and then estimated annually for the remaining 30 years. This analysis was conducted from the perspective of healthcare payers. The study protocol was approved by the ethics committee of Beijing Tiantan Hospital. All participants or their legal proxies provided written informed consent.

**Input Parameters**

Model input parameters were drawn from the published literature and directly from the results of the CHANCE trial (Tables 1 and 2). The death rates and the distribution of functional outcomes of patients treated with clopidogrel-
Table 1. Efficacy of Clopidogrel-Aspirin Regimen for TIA and Minor Stroke

<table>
<thead>
<tr>
<th>Model Input</th>
<th>Aspirin-Alone Regimen</th>
<th>Clopidogrel-Aspirin Regimen</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of patients after 90 days</td>
<td></td>
<td></td>
<td>CHANCE trial database</td>
</tr>
<tr>
<td>Minor or no disability (mRS 0 to 2)</td>
<td>0.9233</td>
<td>0.9376</td>
<td></td>
</tr>
<tr>
<td>Moderate disability (mRS 3 to 4)</td>
<td>0.0670</td>
<td>0.0527</td>
<td></td>
</tr>
<tr>
<td>Severe disability (mRS 5)</td>
<td>0.0058</td>
<td>0.0058</td>
<td></td>
</tr>
<tr>
<td>Death (mRS 6)</td>
<td>0.0039</td>
<td>0.0039</td>
<td></td>
</tr>
<tr>
<td>90-day event risks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent stroke</td>
<td>0.1172</td>
<td>0.0820</td>
<td></td>
</tr>
<tr>
<td>Proportion of ICH</td>
<td>0.0264</td>
<td>0.0377</td>
<td></td>
</tr>
<tr>
<td>Major ECH</td>
<td>0.0066</td>
<td>0.0108</td>
<td></td>
</tr>
<tr>
<td>MI</td>
<td>0.0008</td>
<td>0.0012</td>
<td></td>
</tr>
</tbody>
</table>

TIA indicates transient ischemic attack; CHANCE, Clopidogrel in High-risk patients with Acute Non-disabling Cerebrovascular Events Trial; mRS, modified Rankin Score; ICH, intracerebral hemorrhage; ECH, extracerebral hemorrhage; MI, myocardial infarction.

Aspirin or aspirin alone in the first 90 days were based on results from the CHANCE trial, derived directly from the trial database. Major extracranial hemorrhage risk of the two treatment arms at 90 days were estimated by excluding intracranial hemorrhage from total hemorrhage defined by GUSTO (Global Utilization of Streptokinase and Tissue Plasminogen Activator for Occluded Coronary Arteries) criteria, because extracranial hemorrhage were not explicitly defined in CHANCE trial. We assumed all patients stopped the clopidogrel-aspirin regimen and used aspirin alone after 90 days since dual-antiplatelet therapy is not recommended for routine secondary stroke prevention and aspirin alone is more commonly used than clopidogrel alone in the long-term setting after TIA and minor stroke. Recurrent rates of stroke and the proportion of intracranial hemorrhage (ICH) and fatal cases in recurrent stroke in years after the first 90 days of antiplatelet therapy were estimated from the China National Stroke Registry (CNSR), a nationwide registry for patients with acute cerebrovascular events in China between September 2007 and August 2008, recruiting 21,902 consecutive patients from 132 hospitals that cover all 27 provinces and four municipalities in China, and the Nanjing Stroke Registry Program (NSRP), a total of 1432 patients with first-ever ischemic stroke registered from July 2002. We further assumed an increase in stroke recurrence rates by 1.017-fold per life-year, according to the relative risk estimated from CNSR. Patients remaining alive after recurrent stroke events were assumed to be reallocated equally among disability categories of equal and greater disability. For example, patients with minor or no disability who had a recurrent stroke and lived were allocated equally among minor or no disability, moderate disability, and severe disability categories. Age-specific mortality rates for nonstroke death were derived from the most recent published census of China and adjusted by the causes of death of 2010 reported in the China Health Statistics Yearbook 2012.

In our model, myocardial infarction and major extracranial hemorrhages were considered temporary health states unless they resulted in death. These probabilities were derived from the literature. For nonfatal myocardial infarction and nonfatal major extracranial hemorrhage, we further assumed that all patients entering these health states would have a short-term disutility of only 2 weeks for nonfatal major extracranial hemorrhage and 30 days for nonfatal myocardial infarction.

Costs

All costs were total costs, including both out-of-pocket costs and reimbursement levels, and converted to 2011 Chinese Yuan Renminbi (CNY) by using the medical care component of consumer price index. One-time hospitalization costs for major events and annual posthospitalization costs were based on CNSR and the China Health Statistics Yearbook 2012. Additional costs of the 90-day clopidogrel-aspirin regimen were based on the retail price of clopidogrel (brand) and aspirin according to Beijing Municipal Commission of Development and Reform. Indirect economic costs such as lost work productivity were not included in this analysis. All costs and utilities were discounted by 3% per year.

Health States

In the model, patients could undergo transitions between four poststroke disability states based on the modified Rankin Scale (mRS): minor or no disability (mRS 0 to 2), moderate disability (mRS 3 to 4), severe disability (mRS 5), or death (mRS 6). At the end of each annual cycle, patients could remain in their current health state, transition to a lower health state due to recurrent stroke, or die due to a recurrent stroke or a nonvascular cause (see Figure 1).

Outcome Assessment

Health outcomes were measured in QALYs by multiplying years of life by utility scores derived from the literature. Utility estimates for stroke survivors were based on published utility values stratified by mRS category. Economic costs were measured as the difference of health...
The incremental cost-effectiveness ratio (ICER) was calculated by dividing the cost difference by the difference in QALYs. Using the threshold of 3× GDP per capita of China in 2011 as the willingness-to-pay per QALY, a threshold recommended by the Commission on Macroeconomics and Health of World Health Organization, the intervention was considered cost-effective if the ICER was <CNY 105 000 (3× GDP per capita of China in 2011, US$ 16 200) per QALY gained.

### Sensitivity Analysis

One-way sensitivity analyses were performed to test the robustness of model results on all variables across plausible ranges determined a priori. Plausible ranges were obtained from the literature or by varying estimates up to 20% in each direction (Table 2). To evaluate the impact of the uncertainty in all variables simultaneously, a probabilistic sensitivity analysis was performed using Monte Carlo simulation in Ersatz v1.3 (a bootstrap add-in for Microsoft Excel for Windows; EpiGear International Pty Ltd). Costs were varied after assuming a lognormal distribution. Probabilities and utilities were varied according to a beta distribution. The simulation was run 10 000 times to capture stability of the results. Uncertainty was represented on a scatter-plot and cost-effectiveness acceptability curve.
Results

Base-Case Analysis

In the base-case scenario, for a 63-year-old patient with acute minor stroke or TIA, early 90-day clopidogrel-aspirin regimen would result in a lifetime gain of 0.037 QALY at an additional cost of CNY 1250 (US$ 192) (Table 3). Therefore, the ICER of early 90-day clopidogrel-aspirin regimen would be approximately CNY 33 800 (US$ 5200) per QALY gained. Using the threshold of CNY 105 000 (3 × GDP per capita of China in 2011, US$ 16 200) as the willingness-to-pay per QALY, early 90-day clopidogrel-aspirin regimen was more cost-effective in the base-case scenario.

Sensitivity Analysis

One-way sensitivity analyses indicated that the study results were robust. The tornado diagram in Figure 2 illustrates the effect of varying input parameters on the ICER. Overall, results were most sensitive to additional cost of 90-day clopidogrel regimen and annual posthospitalization cost of disabling stroke (mRS 3 to 5). When additional cost of 90-day clopidogrel regimen was decreased to CNY 210 (based on the generic clopidogrel price in the United States), the ICER of clopidogrel-aspirin decreased to CNY 14 300/QALY, which represents a cost saving with improved health. When annual posthospitalization cost of disabling stroke was varied from CNY 14254.6 to CNY 3239.7, the dual-antiplatelet therapy’s ICER increased from CNY 25 000/QALY to CNY 53 500/QALY. The ICER was relatively insensitive to varying parameters of proportion of ICH in recurrent stroke, utility of major extracranial bleed, utility of myocardial infarction, and hospitalization cost of ICH.

Results of 10 000 iteration probabilistic sensitivity analysis are shown in Figure 3. In 10.6% of simulation runs, the clopidogrel-aspirin therapy was less costly and more effective than aspirin-alone therapy. Clopidogrel-aspirin therapy was cost-effective in 95.7% of the simulations at a willingness-to-pay threshold of CNY 105 000 (3 × GDP per capita of China in 2011, US$ 16 200) per QALY. It remained cost-effective in 49.0% of the simulations at a willingness-to-pay threshold of CNY 35 100 (1 × GDP per capita of China in 2011, US$ 5400) per QALY. A cost-effectiveness acceptability curve shows the probability of cost-effectiveness of the clopidogrel-aspirin regimen as a function of the willingness-to-pay threshold (Figure 4).

Table 3. Cost and QALYs per Capita in Base-Case Analysis

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Cost (CNY)</th>
<th>QALYs</th>
<th>ICER (CNY/QALY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin-alone regimen</td>
<td>136 850</td>
<td>6.461</td>
<td>—</td>
</tr>
<tr>
<td>Clopidogrel-aspirin regimen</td>
<td>138 100</td>
<td>6.498</td>
<td>33 784</td>
</tr>
</tbody>
</table>

QALY indicates quality-adjusted life-year; CNY, Chinese Yuan Renminbi; ICER, incremental cost-effectiveness ratio.

Figure 2. One-way sensitivity analyses on incremental cost per quality-adjusted life-year (ICER) gained by 90-day clopidogrel-aspirin regimen. All parameters were analyzed, and only those with highest influence on ICER are displayed. The first number listed after the variable name is the base-case value. Numbers listed in parentheses indicate the range of the variable. Dark-shaded bars represent the lower bound of the variable range. Light-shaded bars represent the upper bound. Solid vertical lines represent ICER of the clopidogrel-aspirin regimen at the base-case scenario (CNY 33 800). CNY indicates Chinese Yuan Renminbi; MI, myocardial infarction; QALYs, quality-adjusted life-years.
Based largely on the results of the CHANCE trial, this cost-effectiveness analysis demonstrates that a 90-day clopidogrel-aspirin regimen increases costs but improves quality of life. A patient on dual antiplatelet therapy gained an additional 0.037 QALY over a lifetime but at an additional cost of CNY 1250 (US$ 192), resulting in an ICER of CNY 33 800 (US$ 5200) per QALY. The robustness of our overall conclusion that 90-day clopidogrel-aspirin regimen is cost-effective is supported by the sensitivity analysis. The lifetime gain of 0.037 QALY (0.44 quality-adjusted months) for early 90-day clopidogrel-aspirin regimen of TIA and minor stroke is comparable to that of most stroke treatments. For example, the lifetime QALY gain is 0.56 for tissue plasminogen activator treatment for acute ischemic stroke in the 3-hour time window,27 0.17 for clopidogrel (compared with aspirin) for secondary prevention in stroke patients.15 The gain of QALYs associated with early 90-day clopidogrel-aspirin regimen of TIA and minor stroke is relatively smaller than that of other treatments mainly because, unlike other analyses did, our analysis referred to nondisabling cerebrovascular events (TIA and minor stroke) other than stroke with high severity.

Cost-effectiveness was sensitive to the additional cost of 90-day clopidogrel regimen and the annual posthospitalization cost of disabled stroke. When clopidogrel price was decreased to CNY 78 (US$ 12, the generic clopidogrel price in US) for a 1-month supply, the additional cost of 90-day clopidogrel regimen was decreased, and dual-antiplatelet therapy became cost saving. If the annual posthospitalization cost of disabling stroke was reduced to approximately one-third of the base-case level, cost saving from dual antiplatelet therapy was decreased, but the resultant ICER was still substantially lower than the willingness-to-pay threshold.

In current guidelines for the early management of patients with acute ischemic stroke published by both the cerebrovascular disease group of Chinese Medical Association and by the American Heart Association/American Stroke Association, clopidogrel and aspirin combination therapy is not recommended for patients with minor ischemic stroke and TIA.28,29 Aspirin monotherapy is the current standard of care in China. However, guidelines have not incorporated results of the CHANCE trial and patients with aspirin monotherapy still have 90-day stroke risk of 10% to 20% after minor ischemic stroke or TIA.1–3 Our study suggested that clopidogrel-aspirin combination therapy is a cost-effective alternative over aspirin monotherapy when taken soon after a TIA or minor stroke.

Our study has limitations that should be considered when interpreting the results. First, the external generalizability of our findings may be affected as it is based on the efficacy findings from a single trial performed in China (the CHANCE trial), whose participants were restricted to Chinese patients. It is not known whether combination regimen will be shown to be similarly effective in other populations or settings. Additionally, we used a base-case cohort based on the CHANCE trial patient characteristics (mean age was

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**Discussion**

Based largely on the results of the CHANCE trial, this cost-effectiveness analysis demonstrates that a 90-day clopidogrel-aspirin regimen increases costs but improves quality of life. A patient on dual antiplatelet therapy gained an additional 0.037 QALY over a lifetime but at an additional cost of CNY 1250 (US$ 192), resulting in an ICER of CNY 33 800 (US$ 5200) per QALY. The robustness of our overall conclusion that 90-day clopidogrel-aspirin regimen is cost-effective is supported by the sensitivity analysis. The lifetime gain of 0.037 QALY (0.44 quality-adjusted months) for early 90-day clopidogrel-aspirin regimen of TIA and minor stroke is comparable to that of most stroke treatments. For example, the lifetime QALY gain is 0.56 for tissue plasminogen activator treatment for acute ischemic stroke in the 3-hour time window,27 0.17 for clopidogrel (compared with aspirin) for secondary prevention in stroke patients.15 The gain of QALYs associated with early 90-day clopidogrel-aspirin regimen of TIA and minor stroke is relatively smaller than that of other treatments mainly because, unlike other analyses did, our analysis referred to nondisabling cerebrovascular events (TIA and minor stroke) other than stroke with high severity.

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Conclusions

Early treatment with a 90-day clopidogrel-aspirin regimen for acute TIA or minor stroke is highly cost-effective in China setting. Although clopidogrel is generic, Plavix is brand in China. If Plavix were generic, treatment with clopidogrel-aspirin would have been cost saving.

Sources of Funding

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Disclosures

Dr Johnston is the principal investigator of the POINT trial, a NIH-sponsored trial with clopidogrel and placebo donated by Sanofi.

References


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