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Cost-Effectiveness of Magnetic Resonance Angiography Versus Intra-arterial Digital Subtraction Angiography to Follow-Up Patients With Coiled Intracranial Aneurysms

Joanna D. Schaafsma, MD; Hendrik Koffijberg, PhD; Erik Buskens, MD, PhD; Birgitta K. Velthuis, MD, PhD; Yolanda van der Graaf, MD, PhD; Gabriël J.E. Rinkel, MD

Background and Purpose—To follow up patients with coiled intracranial aneurysms, magnetic resonance angiography (MRA) is a promising noninvasive alternative to current standard intra-arterial digital subtraction angiography (IA-DSA). MRA test results do not always concord with those of IA-DSA, and the impact of discrepancies on health benefits and costs is unknown. We evaluated the cost-effectiveness of follow-up with MRA vs IA-DSA to assess whether in this setting MRA may replace IA-DSA.

Methods—We studied aneurism occlusion on MRA in addition to follow-up IA-DSA in 310 patients with 341 coiled intracranial aneurysms. The observed sensitivity (82%) and specificity (89%) of MRA for detection of reopening with IA-DSA as a reference were used as input for a Markov decision-analytic model. Other determinants were derived from the literature. We compared life expectancy, quality-adjusted life-years (QALY), costs, and expected number of events for the two strategies.

Results—Follow-up with MRA yielded similar life expectancy (MRA, 26.66 years; IA-DSA, 26.63 years; difference, 0.03 years; 95% CI, −0.17−0.23) and QALY (MRA, 10.96; IA-DSA, 10.95; difference, 0.01 QALY; 95% CI, −0.05−0.08) at lower costs (MRA, $7003; IA-DSA, $8241 per patient; difference, −$1238; 95% CI, −$2617−$36). The expected number of events was comparable except for complications from IA-DSA.

Conclusion—MRA provided equivalent health benefits as IA-DSA and was cost-saving. MRA dominates and should replace routine IA-DSA to follow-up patients with coiled aneurysms. (Stroke. 2010;41:1736-1742.)

Key Words: cost-benefit analysis ■ digital subtraction angiography ■ intracranial aneurysm ■ magnetic resonance angiography

Follow-up after occlusion of intracranial aneurysms with coils is required because reopening and subsequent rupture may occur.1-3 Intra-arterial digital subtraction angiography (IA-DSA) is the standard modality to detect reopening after coiling but is invasive and irradiating.4 Furthermore, the procedure may cause patient discomfort and requires substantial capacity of the angiography suite and inpatient clinic. Magnetic resonance angiography (MRA) is an alternative technique that is noninvasive, nonirradiating, and can be performed in an outpatient setting.

To investigate whether MRA can replace IA-DSA for follow-up of coiled patients, complete diagnostic evaluation of MRA is required. This should include assessment of its test characteristics, effect on clinical outcome, and cost-effectiveness.5

Although test characteristics have been reported, we could not find studies on effects on clinical outcome and cost-effectiveness in this clinical setting. In a large prospective series of patients, we have recently compared MRA and IA-DSA to assess reopening of coiled aneurysms.6 This enabled us to use the observed test characteristics of MRA with IA-DSA as a reference to assess the expected changes in health benefits and costs incurred using MRA or IA-DSA.

Materials and Methods
Using a cross-sectional design, we previously assessed the accuracy for detection of reopened aneurysms in MRA with IA-DSA as a reference in 310 coiled patients (mean age, 51±12; 71% women).6 Unenhanced (time-of-flight) and contrast-enhanced MRA were performed in each patient in addition to routine IA-DSA. Two observers classified, independently from each other, the level of occlusion as

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activities entered the model at 6 months after coiling for the first time they regain independence for daily activities after subarachnoid hemorrhage. In clinical practice, coiled patients are eligible for follow-up IA-DSA procedures could cause disability and death (Figure 2).

Figure 1. State transition model. Possible transitions between health states (circles) in our Markov model. Patients may develop reopening, remain in the same health state, or may move to the disability and death state because of complications of diagnostic testing, recoiling, rebleeding, or unrelated events.

Evaluation of Health Benefits and Costs: A Markov Model
We developed a Markov decision-analytic model (TreeAge Software) to assess differences in health benefits and costs for follow-up with MRA vs follow-up with IA-DSA. A Markov model is based on probabilities of transitions between health states that we predefined as “healthy with an occluded aneurysm,” “healthy with a reopened aneurysm,” “disabled” (severe disability requiring a nursing home), and “death” (Figure 1). To each health state we assigned a measure for utility that was ultimately used to estimate quality-adjusted life-years (QALY). Various events could cause transitions between health states, such as complications of the diagnostic procedure or treatment, recurrent subarachnoid hemorrhage, or unrelated events. The probabilities of occurrence of these events and their costs were the input parameters for the model. Then, a hypothetical cohort of patients was run through the model with 1-month time cycles. All started in “healthy with an occluded aneurysm” and could transit to other health states depending on occurring events. A lifetime horizon was used. This allowed us to simulate the individual life course of a large hypothetical cohort to assess the change in health benefits (QALY) and costs for a follow-up strategy with MRA vs IA-DSA.

Model Scenarios
In clinical practice, coiled patients are eligible for follow-up IA-DSA when they regain independence for daily activities after subarachnoid hemorrhage. In analogy to clinical practice, our model structure was as follows: fictive patients who were independent for daily activities entered the model at 6 months after coiling for the first follow-up procedure, which was either IA-DSA or MRA. In case of detected aneurysm reopening, patients could be recoiled. Recoiling was also considered for patients with a falsely assumed reopening on MRA. The coiling procedure that requires IA-DSA would be interrupted on detecting an aneurysm on IA-DSA that is actually sufficiently occluded. Conversely, undetected reopened aneurysms on MRA or untreated reopened aneurysms could cause recurrent subarachnoid hemorrhage. A second follow-up procedure was performed at 18 months after coiling. If the aneurysm was still occluded at 18 months of follow-up, then patients were discharged. Patients with untreated reopened aneurysms at 18 months after coiling were screened once more at 3.5 years after coiling. If the aneurysm was left untreated after the 3.5-year screening, then patients were discharged from follow-up. Complications of screening and recoiling procedures could cause disability and death (Figure 2).

Model Parameters
Age, gender, sensitivity and specificity of MRA, and probability of recoiling obtained from our clinical cohort were used as input parameters of the Markov model. Other input parameters on probabilities of health state transitions, utilities, and costs were derived from the literature after a systematic PubMed search. All parameters were discussed in a multidisciplinary setting (Table 1). Patients who died from unrelated causes, we used age- and gender-specific mortality rates provided by the national center of statistics in the Netherlands, adjusted for the standardized mortality ratios of patients after subarachnoid hemorrhage. The risk of reopening of coiled aneurysms decreases over time. Based on the results of studies with different time intervals of follow-up, we developed a univariate regression function to predict long-term reopening rates of patients after subarachnoid hemorrhage. In our baseline scenario, we evaluated the outcomes for 50-year-old patients with parameter values as in Table 1. Simulations were performed for 2500 hypothetical cohorts consisting of 5000 patients each. We compared life expectancy, health benefits in QALY, inherent costs, and the expected number of events for follow-up with IA-DSA and for follow-up with MRA. We repeated the analysis for 35- and 65-year-old patient subgroups. We also performed cost-effectiveness analyses for the 3 age subgroups with a discount rate of 1.5% instead of 4% for costs and effects. Because the aim of follow-up is to prevent recurrent subarachnoid hemorrhage, and because insufficient data on the rupture risk of reopened aneurysms were available, we repeated the analysis for different rupture rates.

Sensitivity Analyses
We explored uncertainty regarding the model input parameters with probabilistic sensitivity analysis using Monte Carlo simulation. We performed additional univariate sensitivity analysis for all model parameters defined by distributions to evaluate the association
between the model parameters with associated uncertainty and changes in costs, effects in QALY, and cost-effectiveness.16

**Results**

For the baseline model, life expectancy and QALY were in the same range for follow-up with MRA and for follow-up with IA-DSA, whereas MRA significantly reduced costs (Tables 2 and 3, Figure 3).

MRA induced health gain while saving costs in 67% of our samples and induced health gain while increasing costs in 1%. Conversely, MRA reduced health benefits at lower costs in 31% of our samples and reduced health benefits at increased costs in 1% (Figure 3).

Life expectancy was 39.42 years (95% CI, 39.03–39.80) after IA-DSA vs 39.47 years (95% CI, 39.04–39.91) after MRA for 35-year-old patients, 26.63 years (95% CI, 26.31–26.95) after IA-DSA vs 26.66 years (95% CI, 26.35–26.98) after MRA for 50-year-old patients, and 15.81 years (95% CI, 15.59–16.02) after IA-DSA vs 15.82 years (95% CI, 15.59–16.02) after MRA for 65-year-old patients.

The number of events during follow-up with IA-DSA and MRA was not different except for case fatality and morbidity caused by IA-DSA (Table 2). The incidence of recurrent subarachnoid hemorrhage was not significantly higher for MRA than for IA-DSA. The difference in the overall case fatality and morbidity between the diagnostic strategies was 9 out of 5000 patients in favor of follow-up by MRA.

Scenario analyses for different ages, discount rates, and rupture rates of reopened aneurysms yielded similar results as for the baseline model. MRA remained cost-saving with a similar change in QALY compared to IA-DSA (Table 3). For 50-year-old patients MRA gained slightly more QALY in 68%, for 35-year-old patients in 72%, and for 65-year-old patients in 64% of the sampled cohorts. The probability of health gain by MRA increases with decreasing age. The cost-saving provided by MRA was similar in all our scenarios and was apparently not largely influenced by patient age, the rupture risk, or the discount rate used in the model.

Sensitivity analysis demonstrated that the distribution of input parameters did not significantly influence costs or QALY. We did not find an association between values of single-model parameters and cost-effectiveness estimates.

**Discussion**

Follow-up after coiling of intracranial aneurysms by MRA results in similar health benefits but lower costs than follow-up by IA-DSA. The expected number of events was similar for both strategies, except for morbidity and case fatality caused by IA-DSA. Nevertheless, these complications did not have a major impact on cost-effectiveness because the total number of expected complications of IA-DSA remained small, particularly in comparison to patients with atherosclerosis.4 The complication risk of MRA with contrast agent is extremely small.17,18 We incorporated this small risk into the
model, even though in our clinical study and other studies contrast-enhanced MRA did not provide significant additional information for unenhanced MRA.19,20 So, the administration of contrast agent is often unnecessary, which decreases the morbidity risk of MRA even further. Moreover, those reopened aneurysms on IA-DSA that were not identified on MRA did not significantly increase the expected incidence of subarachnoid hemorrhage for patients followed-up with MRA. As a result of less than optimal quality of life after subarachnoid hemorrhage, life expectancy considerably surpasses the number of QALY, regardless of the strategy.

MRA appeared to be cost-saving. Because the number of events does not largely differ between the two strategies, the difference in costs is likely to be caused by the lower costs of MRA compared to the IA-DSA procedure. When cost reduc-

Table 1. Model Input Parameters

<table>
<thead>
<tr>
<th>Model Parameter</th>
<th>Value</th>
<th>95% CI/Range*</th>
<th>Distribution</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Probabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensitivity MRA</td>
<td>0.82</td>
<td>0.72–0.89</td>
<td>Beta CS</td>
<td></td>
</tr>
<tr>
<td>Specificity MRA</td>
<td>0.89</td>
<td>0.85–0.93</td>
<td>Beta CS</td>
<td></td>
</tr>
<tr>
<td>$P$ (case fatality of IA-DSA)</td>
<td>0.0006</td>
<td>0.0003–0.0010</td>
<td>Beta 4</td>
<td></td>
</tr>
<tr>
<td>$P$ (morbidity of IA-DSA)</td>
<td>0.0010</td>
<td>0.0006–0.0015</td>
<td>Beta 4</td>
<td></td>
</tr>
<tr>
<td>$P$ (case fatality of MRA)</td>
<td>0.0000000</td>
<td>...</td>
<td>...</td>
<td>17, 18</td>
</tr>
<tr>
<td>$P$ (morbidity of MRA)</td>
<td>0.0000053</td>
<td>0.0000026–0.0000088</td>
<td>Beta 17, 18</td>
<td></td>
</tr>
<tr>
<td>$P$ (case fatality recoiling)</td>
<td>0.0056</td>
<td>0.0018–0.0120</td>
<td>Beta 24–27</td>
<td></td>
</tr>
<tr>
<td>$P$ (morbidity recoiling)</td>
<td>0.011</td>
<td>0.004–0.021</td>
<td>Beta 26, 27</td>
<td></td>
</tr>
<tr>
<td>$P$ (case fatality rebleeding)</td>
<td></td>
<td></td>
<td>Beta</td>
<td>28</td>
</tr>
<tr>
<td>30–39 y</td>
<td>0.182</td>
<td>0.162–0.204</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>40–49 y</td>
<td>0.225</td>
<td>0.211–0.240</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>50–59 y</td>
<td>0.249</td>
<td>0.236–0.262</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>60–69 y</td>
<td>0.317</td>
<td>0.310–0.324</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>70–79 y</td>
<td>0.455</td>
<td>0.438–0.472</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>$&gt;80$ y</td>
<td>0.576</td>
<td>0.553–0.598</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>$P$ (morbidity rebleeding)</td>
<td>0.09</td>
<td>0.08–0.11</td>
<td>Beta</td>
<td>29, 30</td>
</tr>
<tr>
<td>$P$ (case fatality disabled patients) per year</td>
<td>0.24</td>
<td>0.10–0.36</td>
<td>Uniform 28, 31</td>
<td></td>
</tr>
<tr>
<td>$P$ (reopening) up to 6 mo after coiling†</td>
<td>0.119</td>
<td>0.097–0.144</td>
<td>Beta 10, 11, 13</td>
<td></td>
</tr>
<tr>
<td>$P$ (reopening) 6–18 mo after coiling†</td>
<td>0.055</td>
<td>0.019–0.110</td>
<td>Beta 9, 11, 14</td>
<td></td>
</tr>
<tr>
<td>$P$ (reopening) 18 mo–6 y after coiling†</td>
<td>0.036</td>
<td>0.010–0.078</td>
<td>Beta 12</td>
<td></td>
</tr>
<tr>
<td>$P$ (recoiling reopened aneurysm)</td>
<td>0.58</td>
<td>0.47–0.68</td>
<td>Beta CS</td>
<td></td>
</tr>
<tr>
<td>$P$ (rupture risk reopening) per year</td>
<td>0.017</td>
<td>0.014–0.020</td>
<td>Uniform 10, 12, 22, 23, 32</td>
<td></td>
</tr>
<tr>
<td><strong>Costs ($)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costs IA-DSA</td>
<td>$838</td>
<td></td>
<td>...</td>
<td>33</td>
</tr>
<tr>
<td>Costs MRA</td>
<td>$371</td>
<td></td>
<td>...</td>
<td>33</td>
</tr>
<tr>
<td>Costs of rebleeding including recoiling</td>
<td>$36,920</td>
<td>...</td>
<td>...</td>
<td>34, 35</td>
</tr>
<tr>
<td>Costs of elective recoiling</td>
<td>$12,646</td>
<td>...</td>
<td>...</td>
<td>33</td>
</tr>
<tr>
<td>Costs nursing home per year</td>
<td>$107,711</td>
<td>...</td>
<td>...</td>
<td>15</td>
</tr>
<tr>
<td>Costs of patient death</td>
<td>$35,85</td>
<td>...</td>
<td>...</td>
<td>36</td>
</tr>
<tr>
<td><strong>Utilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well after subarachnoid hemorrhage</td>
<td>0.72</td>
<td>0.65–0.80</td>
<td>Triangular 37</td>
<td></td>
</tr>
<tr>
<td>Disabled</td>
<td>0.25</td>
<td>0.21–0.30</td>
<td>Triangular 37</td>
<td></td>
</tr>
<tr>
<td>Dead</td>
<td>0</td>
<td>...</td>
<td>...</td>
<td></td>
</tr>
<tr>
<td><strong>Discounting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost discount per year</td>
<td>4%</td>
<td>...</td>
<td>...</td>
<td></td>
</tr>
<tr>
<td>Effect discount per year</td>
<td>4%</td>
<td>...</td>
<td>...</td>
<td></td>
</tr>
</tbody>
</table>

CS indicates data obtained from our clinical study; IA-DSA, intra-arterial digital subtraction angiography; MRA, magnetic resonance imaging.

*95% CI for beta distribution; range for uniform/triangular distribution.
†A mathematical function based on these results was used (provided online). All rates obtained were converted to probabilities per month.
We intended to construct a detailed Markov model that appropriately reflects clinical practice, although we faced some limitations. First, IA-DSA is not a perfect reference standard for follow-up of coiled aneurysms. For example, the 2-dimensional images restrict visualization of residual flow in case of superimposition of coils or surrounding arteries. Consequently, discrepant results on MRA had to be labeled as “false-positive” or “false-negative,” whereas MRA may provide the more realistic visualization. Thus, the model represented the least favorable scenario for MRA and therefore may underestimate its diagnostic performance. MRA still appeared dominant, thus strengthening the conclusion that MRA may replace IA-DSA.

Second, input parameters originated from our clinical study and from the literature. Because coiling has been available since 1992, only limited data on reopening and subsequent rupture rates more than 5 to 10 years after coiling are available. Reopening rates could only be estimated from a few studies with a systematic long-term follow-up at fixed time intervals.

Third, for the model, we assumed a similar rupture rate for aneurysms that reopened after follow-up for untreatable and for undetected reopened aneurysms, whereas the actual rupture risks may differ in each situation. Undetected reopened aneurysms in our clinical study were smaller and therefore probably had a lower rupture rate than larger reopened aneurysms that are left untreated. By assuming a similar rupture rate, we overestimated the health loss from undetected aneurysms when using MRA and therefore underestimated the health benefits provided by MRA. Repeated analyses for different rupture rates resulted in marginal and similar changes in QALY and costs. So, the uncertainty around the exact rupture rate did not influence the cost-effectiveness of MRA compared to IA-DSA. We furthermore assumed that reopened aneurysms never occlude spontaneously. In case of spontaneous occlusion, the potential hazard of a nonidentified reopened aneurysm on MRA would be smaller. So, again, we applied the least favorable scenario for MRA to avoid positive bias.

### Table 2. Costs and Effects for Follow-Up With IA-DSA vs MRA

<table>
<thead>
<tr>
<th></th>
<th>IA-DSA</th>
<th>MRA</th>
<th>Difference</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs, $</td>
<td>8241</td>
<td>7003</td>
<td>–1238</td>
<td>–2617–36*</td>
</tr>
<tr>
<td>QALY</td>
<td>13.40</td>
<td>13.42</td>
<td>–0.02</td>
<td>(–0.04–0.08)</td>
</tr>
</tbody>
</table>

The cost-effectiveness estimates based on simulations of 2500 cohorts of 5000 patients each.

IA-DSA, intra-arterial digital subtraction angiography; MRA, magnetic resonance imaging; QALY, quality-adjusted life-year.

*Statistically significant.

### Table 3. Scenario Analyses

<table>
<thead>
<tr>
<th>Age, y</th>
<th>DR, %</th>
<th>Rupture Risk</th>
<th>Costs, $</th>
<th>QALY</th>
<th>ΔCosts</th>
<th>95% CI</th>
<th>ΔQALY</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>4</td>
<td>0.017</td>
<td>8240</td>
<td>IA-DSA</td>
<td>13.40</td>
<td>–1238</td>
<td>(–2663–75)</td>
<td>0.02</td>
</tr>
<tr>
<td>50</td>
<td>4</td>
<td>0.017</td>
<td>8241</td>
<td>MRA</td>
<td>10.95</td>
<td>–2617–36</td>
<td>0.01</td>
<td>(–0.05–0.08)</td>
</tr>
<tr>
<td>65</td>
<td>4</td>
<td>0.017</td>
<td>8290</td>
<td>IA-DSA</td>
<td>7.95</td>
<td>–1275</td>
<td>(–2523–199)</td>
<td>0.01</td>
</tr>
<tr>
<td>35</td>
<td>1.5</td>
<td>0.017</td>
<td>11 322</td>
<td>IA-DSA</td>
<td>20.76</td>
<td>–1254</td>
<td>(–2899–290)</td>
<td>0.03</td>
</tr>
<tr>
<td>50</td>
<td>1.5</td>
<td>0.017</td>
<td>10 438</td>
<td>MRA</td>
<td>15.29</td>
<td>–1284</td>
<td>(–2979–72)</td>
<td>0.02</td>
</tr>
<tr>
<td>65</td>
<td>1.5</td>
<td>0.017</td>
<td>9 743</td>
<td>IA-DSA</td>
<td>9.90</td>
<td>–1340</td>
<td>(–2894–50)</td>
<td>0.01</td>
</tr>
<tr>
<td>50</td>
<td>4</td>
<td>0.034</td>
<td>9 284</td>
<td>MRA</td>
<td>10.90</td>
<td>–1227</td>
<td>(–2588–6)</td>
<td>0.01</td>
</tr>
<tr>
<td>50</td>
<td>4</td>
<td>0.014</td>
<td>7 897</td>
<td>IA-DSA</td>
<td>10.98</td>
<td>–1244</td>
<td>(–2295–108)</td>
<td>0.02</td>
</tr>
<tr>
<td>50</td>
<td>4</td>
<td>0.009</td>
<td>7 546</td>
<td>MRA</td>
<td>10.98</td>
<td>–1255</td>
<td>(–2492–61)</td>
<td>0.01</td>
</tr>
<tr>
<td>50</td>
<td>4</td>
<td>0.005</td>
<td>7 135</td>
<td>IA-DSA</td>
<td>11.00</td>
<td>–1264</td>
<td>(–2677–122)</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Each analysis comprised 1000 simulations for 5000 patients.

DR, discount rate; IA-DSA, intra-arterial digital subtraction angiography; MRA, magnetic resonance imaging; QALY, quality-adjusted life-year.

*Rupture risk of reopened aneurysm per year.
Fourth, we did not evaluate the influence of uncertainty in costs on the cost-effectiveness of MRA vs IA-DSA because insufficient evidence was available to define their distribution. Finally, because information on actual dependencies between model parameters could not be obtained, all parameters were, by necessity, assumed to be independent in our probabilistic sensitivity analysis. This assumption may not hold for all parameters, e.g., for sensitivity and specificity. Nevertheless, because the sensitivity analyses showed overall robust outcomes, we feel that our general conclusion remains justified.

MRA is a safe technique that can be performed in an outpatient setting. Our results show that the consequences of misdiagnosis by MRA outweigh the complications caused by IA-DSA and that MRA reduces costs. We therefore recommend using MRA instead of IA-DSA to follow-up coiled patients. The exact timing of reopening and subsequent rupture after coiling is unclear. Additional studies on timing of follow-up MRA are warranted to assess the short-term and long-term evolution of coiled aneurysms.

Conclusion
Cost-effectiveness analysis by Markov modeling shows that potential consequences of misdiagnosis by MRA outweigh the complications caused by IA-DSA and that MRA reduces costs. We therefore recommend using MRA instead of IA-DSA to follow-up coiled patients. The exact timing of reopening and subsequent rupture after coiling is unclear. Additional studies on timing of follow-up MRA are warranted to assess the short-term and long-term evolution of coiled aneurysms.

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Disclosures
None.

References


