Objective costs were identified by patient's weight and height at the beginning of the study. 

The main driver of the model was GFR level and the dynamics of GFR changes, which determined the actual stage of the patients that assigned the corresponding costs and utilities. The control arm corresponds with the existing practice of Ketosteril (a ketoacid-aminoacid oral preparation) in stage 3 of CKD patients (GFR<25 ml/min), while the active arms were modeled the earlier start of Ketosteril therapy in stage 3-4 of CKD patients. 

To assess the qualitative and quantitative impact of the two different Ketosteril approaches. Deterministic and probabilistic analyses were conducted from a payer perspective.

**Internal Validity**

The time horizon was defined on 30 years. Exchange rate was set on the basis of the GFR level according to the international guidelines.

**Simulation modeling:** basically 1000 new hypothetical patient curves (i.e. equation coefficients) were generated from the original patient data. Bayesian conditional probability was used to reflect limitations of the short term data regarding long term disease progression on the basis of published literature.

**RESULTS:**

The majority of cases in the 19 CBO iteration of the probabilistic analysis can be found in the dominant field. A result of the probabilistic analysis presented on a scatter plot figure. 85.3% of the cases (IC cost) Ketosteril therapy resulted a dominant vs CKD3 Ketosteril therapy.

**CONCLUSIONS**

Our analysis presented three different methodological approaches to evaluate the cost-effectiveness of Ketosteril treatment of stage 3 compare to stage 4 of CKD. The cost-utility analysis demonstrated that Ketosteril treatment in stage 3 CKD was a dominant strategy compared to stage 4 CKD in Hungary and a significant reduction of estimated cost burden for health care systems. 

The following histogram includes those few (total 2 813 cases, 14.6%) subjects where cost-effectiveness threshold rate were relevant. The majority of cases is located within interval between -8 000-400 000 EUR/QALY.

**REFERENCES**

- Szafraniec et al: Bayesian approaches to clinical trials and healthcare evaluation. Wiley 2004