patients with no episodes (HR 7.5, 95% CI 2.6–22.0, P < 0.01). CONCLUSIONS: Upper GI symptoms were significantly associated with poor adherence to and discontinuation of low-dose ASA. Strategies to help patients continue with low-dose ASA cardio-protection are warranted.

PCV112
DIFFERENCES IN PERSISTENCE BETWEEN CCBs WHEN COMBINED WITH AN A2RA OR AN ACE ANTIHYPERTENSIVE IN AUSTRALIA
Craig MG, Caloio G1, Saly Pharmaceuticales Australia, Pyrmble, NSW, Australia, 2Health Connections Pty Ltd, Wolstenholme, ACT, Australia
OBJECTIVES: To assess persistence to the combinations of dihydropyridine (DHP) calcium channel blocker (CCB) with an Angiotensin Converting Enzyme (ACE) inhibitors or an Angiotensin II Receptor Antagonist (A2RA), using PBS claims data provided by Medicare Australia. METHODS: This analysis is based on all scripts supplied to a one in ten sample of the Australian population drawn from de-identified Pharmaceutical Benefits payment records from January 2003 to December 2006. Initiation occurred with 2 consecutive months of an A2RA or an ACE combined with a DHP following at least 6 months without a DHP combination. Treatment cessation was 3 consecutive months of non use or just one of the drugs making up the combination. Hazard ratios (HR) were derived and adjusted for patient age/sex and initiating specialty. RESULTS: More than 17,500 Conessional patients, initiated on a DHP combined with an A2RA and more than 12,000 Conessional patients, initiated on a DHP combined with an ACE, had their persistence to the combination assessed. Median persistence (50% CI) differed between DHP combinations: Lercanidipine/ A2RA 23 months [22–25], Felodipine/A2RA 20 months [18–22], Nifedipine/ACE 17 months [16–18], and Amlodipine/ACE 14 months [13–15]. Using Lercanidipine/ A2RA as the reference (HR = 1.00), patients were significantly more likely to cease the combination than patients using Felodipine/A2RA (8.7%), Nifedipine/ACE (18.5%), and Amlodipine/ACE (33.9%). Lercanidipine/ACE 24 months [22–26], felodipine/ACE 21 months [19–24], nifedipine/ACE 16 months [14–18], and amloidipine/ACE 15 months [14–17]. Using Lercanidipine/ACE as the reference (HR = 1.00), patients were more likely to cease the other combinations felodipine/ACE (7.2%), nifedipine/ACE (26.5%) and amloidipine/ACE (28.6%). CONCLUSIONS: In terms of optimal treatment persistence, lercanidipine seems to be the best DHP to combine with an A2RA or an ACE, while amloidipine seems to be the worst DHP to combine with an A2RA or an ACE.

PCV113
INFLUENCING FACTORS TO A GOOD ADHERENCE IN PATIENTS WITH CHRONIC HEART DISEASES
Orihara H1, Sugura S, Kumagi N, Sumi S2
University of Toyama School of Medicine, Toyama, Japan
OBJECTIVES: To identify enhancing factors of the medication adherence using the data from a randomized trial of patients with chronic heart diseases. METHODS: We used the data from a randomized trial involving a total of 6967 patients with chronic heart diseases. This trial followed up them with an average of 5 years. Adherence rate was obtained by the division of a number of days to take a targeted medicine by 365 days each year for each patient. The targeted medicine was the one assigned by randomization. An overall adherence rate for each patient was defined by an average of annual adherence rates during the follow-up period. Good medication adherence was defined by the overall adherence rate of 80% or more. An adjusted odds ratio (OR) was used to determine the degree of influence to a good adherence. RESULTS: Very high rate (94%) of good adherence was observed since the medication was an assigned drug in a randomized trial. Enhancing the odds of good adherence was women (OR = 1.13, P = 0.007), age (OR per 5 year increase = 2.33, P = 0.17), patients taking 5 or more medicines (OR = 1.45, P = 0.001), and good status on diet therapy (OR = 1.95, P < 0.001). Conversely, smokers decreased the adherence by 12% (P = 0.008) and patients with previous stroke decreased the adherence by 29% (P < 0.001). CONCLUSIONS: Patients taking many drugs or receiving diet therapy and women showed a statistically significant increase in the medication adherence.

PCV114
PREDICTORS OF NON-PERSISTENCE ON STATIN TREATMENTS IN ITALY: A RETROSPECTIVE
Carbonecchia S1, 2, Pinti S1, 2, Raglieri S1, Ciarella A1, Mandetto E1, Mantovani LG1
1University of Naples, Naples, Italy, 2University Federico II, Naples, Italy
OBJECTIVES: The aim of this study was to estimate predictors of non-persistence with different statin treatments by the analysis of the database of a single hospital chain. We base covered a population of 144,000 inhabitants. METHODS: We analysed a cohort of adult patients (>35 years) who newly initiated statin therapy between January 1,2005 and December 31,2005. The initiation status was confirmed by the absence of any drug prescription within 365 days prior to statin initiation. Persistence of statin utilization was analysed over 3 years follow-up period. The period covered by a prescription was defined by the number of tablets dispensed, based on one tablets per day. Treatment was considered discontinued if the interval between two prescriptions exceeded number of tablets prescribed, plus 60 days. Persistence was defined as the period from the first prescription date to the date of discontinuation. A Kaplan-Meier survival analysis and a multivariate Cox proportional hazards regression analysis was performed including in the model all covariates (demographic characteristics, comorbidities, previous therapies) that may potentially confound the association between cohort and outcome. RESULTS: The final sample included 2342 patients (28.4% simvastatin; 7.3% fluvastatin; 13.4% pravastatin; 30.7% atorvastatin; 20.3% rosuvastatin). Only 23.2% of patients persisted for 3 years of therapy. Female gender and absence of diabetes comorbidity were the most significant predictors of early discontinuation. CONCLUSIONS: Further studies are required to evaluate whether these factors are related to persistence to treatment.

PCV115
HEALTH STATUS UILITY VALUES FOR ATRIAL FIBRILLATION AND ASSOCIATED TREATMENT-RELATED ADVERSE EVENTS
Doolan S1, Lloyd A1, Craig AM1
OBJECTIVES: The study aimed to describe common adverse events associated with atrial fibrillation medications, as well as atrial fibrillation (AF) itself. The AF and adverse event descriptions were used to estimate societal utility values in the UK. METHODS: AF base health state descriptions were produced based on EQ-5D-5L data with input from patients and clinicians. Adverse event descriptions were bolted to the EQ-5D derived base AF health states so that the associated disutility of specific treatment adverse events could be described. The health states described both paroxysmal/persistent and permanent AF along with 14 adverse events. Interview with five AF patients were carried out to assess the content of the adverse events and face validity of the health states. In total, 127 members of the UK general public valued the health states in a time trade-off (TTO) interview and ranking task. RESULTS: The study revealed the public preferences for atrial fibrillation and associated adverse event health states. There was a range of disutility reported for the adverse events from -0.01 for dizziness, -0.03 for rash, -0.08 for diarrhoea, -0.10 for hypothyroidism, to -0.17 for pulmonary complications. CONCLUSIONS: The study provides insight into the importance of atrial fibrillation treatment adverse events on patient’s quality of life. As atrial fibrillation is a largely asymptomatic condition, the impacts of treatment adverse events on health related quality of life are amongst the most important factors considered in treatment decisions. The utility values collected in this study may prove useful in populating cost-effectiveness analyses.