duced during a review of the company’s submission (CS) to the National Institute for Health and Care Excellence (NICE) Single Technology Appraisal programme for the oral direct thrombin inhibitor, dabigatran. METHODS: Randomized controlled trials (RCTs) for inclusion were identified using the CS for dabigatran (as part of Technology Appraisal [TA]327), and two similar submissions for rivaroxaban (TA261 and TA287). RCTs with a feasible comparability based on patient population, outcomes, and treatments received. A Bayesian MTC was conducted, and fixed and random effects models were explored. Odds ratio (OR) was chosen as the summary statistic for VTE recurrence and major bleed and so was chosen as the best-fitting model. There was reasonable agreement between the number of unconfirmed data points and the residual deviance for both outcomes. Results compared to dabigatran were (OR = 0.15–3.37), rivaroxaban OR 1.29 (95%CrI: 0.12–5.42), warfarin OR 1.87 (95%CrI: 0.31–6.45); favours dabigatran): VTE recurrence LMWH OR 0.96 (95% Credible Interval [95%CrI]: 0.72–1.29); and warfarin OR 0.97 (95%CrI: 0.78–1.22), NO data were available on major bleed for rivaroxaban in people with active cancer. CONCLUSIONS: There were no significant differences in the outcomes evaluated. However, the available evidence suggests that LMWH may have the lowest risk for VTE recurrence in the treatments assessed.

PCV22

ASSOCIATION BETWEEN ADHERENCE TO EVIDENCE-BASED HEART FAILURE MANAGEMENT AND ALL-CAUSE MORTALITY

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OBJECTIVES: To assess the association between adherence to heart failure (HF) evidence-based treatment (i.e. β-blocker + ACE inhibitor or angiotensin receptor blocker + diuretic or aldosterone blocker + diuretic), and 1) one-year all-cause hospitalization and 2) one-year all-cause mortality, among people newly diagnosed for HF.

METHODS: We conducted two nested case-control studies using Quebec (Canada) medicado-administrative data. We selected cases and controls in a cohort made of Quebec residents ≥18 years who had a first diagnosis of HF between 01/01/2000 and 12/31/2009 and who did not use HF evidence-based treatment for 90 days prior to diagnosis. Cases were hospitalized or had died in the year after HF diagnosis. Each case was randomly matched to 4 to 10 controls using incidence density sampling. Adherence to HF evidence-based treatment was assessed using the proportion of days covered (PDC). Odds ratios (OR) were calculated using conditional multivariable logistic regressions. RESULTS: Among the 125,622 individuals in the cohort, 70,483 (56.1%) were hospitalized and 19,915 (15.9%) died during the first year after diagnosis. Only 7.5% of hospitalization cases, 9.5% of all-cause deaths and prescription for cases stopped due to death prior to 1 year were excluded. Compared to those with a PDC ≥80%, patients who had a PDC < 0% and <80% (OR = 1.39 (95% CI: 1.33–1.46)) or a PDC > 0% (OR = 1.53 (1.48–1.58) were more likely to be hospitalized within the first year after diagnosis. Similarly, compared to those with a PDC ≥80%, patients who had a PDC < 0% and <80% (OR = 1.72 (95% CI: 1.59–1.86)) or a PDC > 0% (OR = 2.26 (1.23–2.40) were more likely to die during the year after diagnosis. CONCLUSIONS: Adherence to HF evidence-based treatment is associated with lower odds of hospitalization and have a detrimental effect on survival of HF patients.

PCV21

SYSTEMATIC REVIEW AND META-ANALYSIS OF SELF-MONITORING AND SELF-MANAGEMENT OF ANTICOAGULATION THERAPY WITH VITAMIN K ANTAGONISTS (OUMAS studi)

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OBJECTIVES: The introduction of prothrombin time (INR) point-of-care devices permits patient self-testing of the INR values and subsequently, also self-adjustment of the dosing regimen. The purpose of this systematic review was to evaluate recent findings regarding the effects of self-monitoring and self-management of anticoagulation therapy with vitamin K antagonists (coumarins) compared to the standard ambulatory care.

METHODS: A comprehensive literature search using OVID MEDLINE (1946 – April 2015) and EMBASE (1974 – April 2015) databases was performed. Selection criteria were restricted to randomized controlled clinical trials evaluating self-monitoring or self-management with standard care as control. Meta-analysis was performed in Review Manager Computer program (Version 5.3) using a fixed-effect model with the Mantel-Haenszel method to calculate the pooled risk ratios (RR) and their 95% confidence interval (CI) of the following clinical outcomes: thromboembolic events, major haemorrhage, and all-cause mortality. Potential heterogeneity was assessed with I² statistics. RESULTS: In addition to the 2010 Cochrane review (Self-monitoring and self-management of oral anticoagulation), 10 new randomized trials were identified, in 3 of them self-monitoring was evaluated, while in the other 7 studies self-management was evaluated. Until the April 2015, self-monitoring and self-management was evaluated in 11 studies (9 RCTs and 2 non-RCTs). Albeit, self-monitoring randomized trials, respectively. Self-management was associated with significant reductions in both thromboembolic events (RR = 0.48, 95%CI: 0.35–0.65, p<0.001) and mortality (RR = 0.45, 95%CI: 0.35–0.69, p<0.001). Self-management of the INR, while significant effect on thromboembolic events was found (RR = 0.70, 95%CI: 0.58–0.84). In contrast to the 2010 Cochrane review, no significant benefit of self-monitoring could be confirmed: the RR was 0.91 (95%CI: 0.71–1.16), 0.91 (95%CI: 0.75–1.00), and 0.94 (95%CI: 0.75–1.17) for the thromboembolic events, major haemorrhage, and all-cause mortality, respectively. COMPARISON: Compared to the standard ambulatory care, patient self-management of the INR values shows beneficial effects on their anticoagulant therapy. Moreover, self-management better improves the probability of the occurrence of thromboembolic events than self-monitoring.

PCV24

LONG-TERM INCREASED INPATIENT AND OUTPATIENT VISITS ASSOCIATED WITH A NEW CARDIOVASCULAR EVENT: A LARGE UNITED STATES REAL WORLD STUDY

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OBJECTIVES: To evaluate the burden to patients and the healthcare system associated with a new cardiovascular event (CVE) up to 3 years post-new CVE among high-risk hyperlipidemia patients.

METHODS: Using the IMS LifeLink PharmPlus Analytics database, we studied patients with new CVE and hyperlipidemia patients with and without a new CVE between 01/2006 and 06/30/2012. CVEs included primary inpatient claims for myocardial infarction (MI), stroke, coronary artery bypass graft (CABG), percutaneous coronary intervention (PCI), and coronary heart disease (CHD). Outpatient visits for heart failure and patients were stratified into two CVE risk cohorts: history with and without CHD and coronary artery disease, abdominal aortic aneurysm, diabetes, dyslipidemia. Propensity score matching was applied to compare the burden among patients with and without a new CVE, ranging from 1 month through 3 years post-CVE date. RESULTS: Using the IMS LifeLink PharmPlus Analytics database, this retrospective cohort study included high CVE risk hyperlipidemia patients...