occurrence of a surgical site infection (SSI) examined by wound closure method. Post-CABG SSIs were identified by ICD-9, DRG, and APR-DRG codes during the initial hospital admission and re-admissions within 2 months of the initial hospitalization, as well as exposure to antimicrobial drugs from postoperative day 9 to 60 during the initial hospital admission. RESULTS: A total of 59,006 patients qualified for the study; 38,799 sutures only, 10,262 sutures/DERMABOND, 8,180 sutures/staples, and 1,765 sutures/staples/DERMABOND. The groups were similar at baseline regarding patient and disease characteristics. The lowest rate of post-CABG SSI was found in the sutures/DERMABOND group (4.3%, 95% CI = 3.9%–4.7%), followed by sutures only (5.3%, 95% CI = 5.1%–5.5%), sutures/staples (6.2%, 95% CI = 5.7%–6.8%), and sutures/staples/DERMABOND (7.1%, 95% CI = 6.0%–8.4%). The mean (median) hospitalization cost for all patients without post-CABG SSI was $28,061 ($25,527), compared to $47,874 ($40,062) for all CABG patients who developed SSI. CONCLUSIONS: The results of this study suggest that the use of both DERMABOND Topical Skin Adhesive and sutures for wound closure following CABG surgery reduces the rate of SSI and improves clinical outcomes. SSI following CABG surgery imposes a significant economic burden in terms of additional hospitalization costs.

PCV107
CLOPIDOGREL PATTERNS OF USE IN ACUTE CORONARY SYNDROME PATIENTS UNDERGOING PERCUTANEOUS CORONARY INTERVENTION IN FIVE EUROPEAN COUNTRIES
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OBJECTIVES: The purpose of this study was to determine the frequency of clopidogrel dosing regimens in the hospital setting for acute coronary syndrome (ACS) patients undergoing percutaneous coronary intervention (PCI). METHODS: This was a retrospective study using the IMS Health Acute Cardiovascular Analyzer. This is an ongoing physician-reported registry dating from 2005 in Germany, France, Italy, Spain and the UK. Data collection timeframe reported here was December 2006–November 2007. The standard dose clopidogrel group was defined as ≤300 mg. Demographic and health characteristics were compiled for the entire cohort and by country. Study data are shown as summary (or descriptive) statistics. RESULTS: There were 4455 ACS patients who received clopidogrel and underwent PCI. Patient count by country was: Germany (n = 1098), France (n = 1022), Italy (n = 864), Spain (n = 804), UK (n = 667). Mean age was 63.7 ± 22.9 (SD) years, 46% were age >65; 71% were male. Common comorbidities and risk factors were: hypertension 66.8%, dyslipidemia 74.6%, diabetes 30.6%, prior myocardial infarction (MI) 12.9%. Medications prior to admission were: clopidogrel 15.9%, statins 34.8%, aspirin 61.3%. The index diagnosis was: ST-elevation MI 45.0%, non ST-elevation MI 33.1% and unstable angina 21.9%. Timing of clopidogrel administration in relation to PCI was: 59.3% pre-PCI, 11.8% at PCI and 17.0% after PCI (11.9% not specified). Loading dose ranged from 75–900 mg. Dosage ≤300 mg by country was: Germany 47.9%, France 67.8%, Italy 90.8%, Spain 83.6%, UK 60.7%. Approximately 95% of patients were discharged on clopidogrel but planned duration varied widely: 1–3 months (25.7%), 6–12 months (19.7%) are greater than or equal to 12 months (26.5%). CONCLUSIONS: These 2007 data indicate many patients received clopidogrel prior to PCI at the ≤300 mg dose but there was geographic variation. The vast majority of patients received clopidogrel upon discharge, but the planned duration of therapy varied widely. These data continue to be useful benchmarks for later comparison to treatment guidelines.

PCV108
RISK AND COSTS OF THE FIRST HYPERTENSION-ASSOCIATED EVENT, COMPLIANCE AND PERSISTENCE IN NAÏVE HYPERTENSIVE PATIENTS AFTER INITIATING MONOTHERAPY
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OBJECTIVES: To analyze the risk and costs of the first hypertension-associated event, compliance and persistence in naïve hypertensive patients after initiating monotherapy with any of the first-line antihypertensive drug classes in Germany. METHODS: A retrospective cohort study in the IMS Disease Analyzer database was performed. Study subjects included all previously untreated hypertensive adults who were free from hypertension-associated comorbidities and were prescribed initial monotherapy with angiotensin II receptor blockers (ARBs), ACE-inhibitors (ACEIs), beta-blockers (BBS), calcium channel blockers (CCBs) or diuretics. Compliance and persistence were determined for each drug class separately and for the group of non-ARBs (pooled data) within two years. The risk of the first hypertension-associated event (cardiovascular complications, new onset diabetes) was analyzed using a Cox regression model adjusted for sociodemographic variables, compliance and persistence. Based on these results average costs per event were estimated from the German statutory health insurance perspective. RESULTS: A total of 7661 patients were identified with a follow-up of at least 2 years. Mean follow-up was 5.6 to 6.3 years. Compliance (0.86 vs. 0.82 and 0.74, respectively) and persistence (509 days vs. 459 and 324 days) was better with ARBs (all p < 0.05) than with the group of non-ARBs and diuretics, respectively. The risk of the first hypertension-associated event was higher (all p < 0.05) with diuretics (adjusted hazard ratio (aHR) 0.68), BBs (0.79), CCBs (0.78), and the group of non-ARBs (0.81) and was similar with ACEIs (aHR 0.93, p = 0.37) compared to ARBs. Similar findings were found for cardiovascular complication rates. The estimated average costs per event for the first event were lower with ARBs (€2399.95) than with the other drug classes (€2531.68–€3910.47). CONCLUSIONS: Our real-world data indicate that initiating monotherapy with ARB shows significant benefits in most outcomes including hypertension-related complications compared to other antihypertensive drug monotherapies.
behavior: diabetics and those with hypertension. METHODS: Analyses are based on a nationally representative sample from the Medicare Current Beneficiary Survey (MCBS) for the years 2000–2005. MCBS is a longitudinal survey and provide detailed information on prescription drug coverage, exercise, weight, diet, alcohol consumption, and smoking behavior. The analysis is restricted to non-institutionalized persons above 64 years of age with at least 2 years of data. We pay particular attention to the non-random nature of prescription drug coverage and the selection bias caused by it. Specifically, estimates are obtained using longitudinal data and multivariable regression models that control for observed characteristics and unmeasured person-specific effects (i.e., fixed effects). RESULTS: An average of 16% of the elderly switched coverage in any two consecutive years, providing sufficient variation in prescription drug coverage to conduct fixed effects analysis. In general, we find limited evidence of prescription drug coverage affecting health behaviors. The lone exception was for those in public programs, where one specification reflected that elderly in the public programs were 13% less likely to exercise after controlling for health status. CONCLUSIONS: Although, we did not find any evidence of ex ante moral hazard with employer-sponsored and HMO coverage, those in public program altered their behavior significantly upon gaining prescription drug coverage.

THE POTENTIAL ECONOMIC IMPACTS OF RECONFIGURING TIA CARE IN THE UK
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OBJECTIVES: The experience of TIA patients in the UK NHS can be quite disparate. Patients presenting to primary care are often referred to a weekly clinic, creating a delay in access to effective treatments for this condition. The recent EXPRESS study by Rothwell et al. (Rothwell, Peter M., et al. Lancet. Online 9 Oct 2007 DOI:10.1016/S0140-6736(07)61448-2) clearly demonstrated that a greater focus on effectively managing TIA could have a significant impact on subsequent stroke rates. We wanted to examine how the implementation of the care pathway outlined in Phase 2 of the EXPRESS study could affect rates of stroke, and to explore the financial implications of such a shift in care. METHODS: We developed an economic model to estimate the costs and savings associated with setting up a rapid assessment and treatment clinic for patients with suspected TIA, in line with Phase 2 of the EXPRESS study. We used a local population of 500,000 people with an assumed annual incidence of TIA of 0.19%. Current management was based on national clinical guidelines and common clinical practice. We included all direct costs associated with care (medications, diagnostics and staff), and modeled the impact of changing management over a three-year time horizon, in line with NHS planning timeframes.
RESULTS: For an assumed population of 500,000, changing the pathway of care for TIA management resulted in 295 future stroke events avoided over three years. As a result, the additional costs associated with changing the pathway of care for TIA were greatly outweighed by the savings generated through avoiding acute management costs associated with stroke. CONCLUSIONS: The model suggests that the implementation of the changes outlined in phase 2 of the EXPRESS study is cost saving for a local population of 500,000 with an assumed TIA rate of 0.19%.