patterns were assessed at 6 months following hospital discharge for patients who received only BMS and for patients with at least 1 DES. **METHODS:** A prospective, observational registry of 11 European countries grouped into 6 clusters recruited ACS patients undergoing PCI from 2008–2009. Interventional cardiologists collected data from ACS events up to hospital discharge, and primary care physicians and cardiologists collected 6-month data. **RESULTS:** Of 3042 eligible patients at baseline, 2964 (97%) had 6-month data, of which 2842 (96%) received a stent at index PCI. The percentage of patients with at least 1 DES was 17% in the Czech Republic, 31% in Germany, 33% in Austria-Hungary, 33% in Belgium-The Netherlands, 37% in the Nordic countries, and 81% in Greece. The percentage of patients taking dual antiplatelet therapy at hospital discharge ranged from 93% in Belgium-The Netherlands to 100% in Greece for BMS only and from 93% in Belgium-The Netherlands to 100% in Czech Republic for patients with DES. At 6 months, the percentage of patients taking dual antiplatelet therapy ranged from 45% in Czech Republic to 97% in Greece for BMS-only patients and from 83% in Belgium-The Netherlands to 97% in Greece for patients with DES. Aspirin use ranged from 89% to 100% across the countries and type of stent. **CONCLUSIONS:** Use of DES versus BMS varied among the European countries. In patients with BMS, there was marked variability with clopidogrel use at 6 months; whereas, in patients with DES, clopidogrel was used more frequently and with less variability.

PCV132

AN INTERNATIONAL COMPARISON OF ANTIPLATELET USE AT 6 MONTHS FOLLOWING HOSPITAL DISCHARGE IN UA/NSTEMI AND STEMI PATIENTS UNDERGOING PCI: RESULTS FROM THE ANTIPLATELET TREATMENT OBSERVATIONAL REGISTRY II (APTOR-II)

Coufal Z[1], Berkenboom G[2], Pavlides G[3], Mohacsi A[4], James S[5], Paget MA[6], Goedicke J[7], Norrbacka K[8], Zeymer U[9]

[1]Bata's Regional Hospital, Zlin, Czech Republic; [2]U.L.B Erasme Hospital Brussels, Brussels, Belgium; [3]Onassis Cardiac Surgery Center, Kallithca, Greece; [4]Hungarian Institute of Cardiology, Budapest, Hungary; [5]Uppsala University Hospital, Uppsala, Sweden; [6]Lilly France S.A., Suresnes Cedex, France; [7]Eli Lilly & Company, Hamburg, Germany; [8]Eli Lilly & Company, Vantaa, Finland; [9]Herzzentrum Ludwigshafen, Ludwigshafen, Germany

OBJECTIVES: Current European Society of Cardiology Guidelines recommend dual antiplatelet therapy for 12 months for all patients with acute coronary syndrome (ACS). The variations in antiplatelet treatment patterns at 6 months following hospital discharge were assessed in patients with unstable angina (UA), non-ST-elevation myocardial infarction (NSTEMI), and ST-elevation MI (STEMI) undergoing percutaneous intervention (PCI). **METHODS:** A prospective, observational registry of 11 European countries grouped into 6 clusters recruited acute coronary syndrome (ACS) patients undergoing PCI from 2008–2009. Interventional cardiologists collected data from ACS events up to hospital discharge, and primary care physicians and cardiologists collected 6-month data. **RESULTS:** Of 3042 eligible patients at baseline, 2964 patients (97%) had 6 month data; 51% of patients presented with STEMI and 49% with UA/NSTEMI. The median age was 62 yrs. At 6 months following hospital discharge, the percentage of UA/NSTEMI and STEMI patients using clopidogrel, respectively, was 70% and 40% in the Czech Republic, 84% and 89% in Germany, 98% and 99% in Greece, 78% and 81% in the Nordic countries, 93% and 94% in Austria and Hungary, and 81% and 88% in Belgium and the The Netherlands. The percentage of UA/NSTEMI and STEMI patients taking aspirin, respectively, was 98% and 99% in the Czech Republic, 89% and 90% in Germany, 97% and 100% in Greece, 95% and 93% in the Nordic countries, 94% and 96% in Austria and Hungary, and 91% and 94% in Belgium and the The Netherlands. **CONCLUSIONS:** Use of clopidogrel varied considerably between European countries at 6 months after discharge, whereas the majority (≥90%) of patients continued to use aspirin. Results suggest that both physician and patient education on continuing dual antiplatelet therapy may be needed.

PCV133

PRACTICE PATTERNS AND QUALITY OF LIFE IN ACUTE CORONARY SYNDROME PATIENTS IN 2008–2009: BASELINE RESULTS FOR GERMANY FROM THE ANTIPLATELET TREATMENT OBSERVATIONAL REGISTRY II (APTOR II)

Zeymer U[1], Norrbacka K[2], Paget MA[3], Goedicke J[4], Clouth J[5]

[1]Herzzentrum Ludwigshafen, Ludwigshafen, Germany; [2]Eli Lilly & Company, Vantaa, Finland; [3]Lilly France S.A., Suresnes Cedex, France; [4]Eli Lilly & Company, Hamburg, Germany; [5]Lilly Deutschland GmbH, Bad Homburg, Hessen, Germany

OBJECTIVES: This analysis aims to explore management of acute coronary syndromes (ACS) from acute event to hospital discharge in Germany, and to measure Quality of Life (QoL) at discharge. **METHODS:** This 12-month international prospective, observational study recruited ACS patients undergoing percutaneous coronary intervention (PCI), April 2008–March 2009, capturing practice patterns, resource use and QoL. **RESULTS:** 500 ACS-PCI patients (out of the 508 recruited) were eligible: median age 63 yrs (IQR 53–72), median weight 82 kg (IQR 74–92), 23% female, 24% Type II diabetics, and 27% prior myocardial infarction (MI). Index diagnosis was: unstable angina or non-ST-elevation MI (UA/NSTEMI)-53% and ST-elevation MI (STEMI)-47%. Almost all patients (96%) received stents: 68% bare metal stents (BMS) only, 29% drug eluting stents (DES) only and 3% both. Time from start of ACS symptoms to PCI was 3 days or less in 91% of UA/NSTEMI patients and 1 day or less in 97% of STEMI patients. Oral antiplatelet medications with loading dose (LD) used: aspirin-86% and clopidogrel-93%. Clopidogrel LD was administered in

the ambulance-7%, previous hospital-8%, emergency room-32%, CCU or ICU-23%, catheterization lab-25%, other ward 5%. LD was administered just before or direct after PCI in 79% of cases. The clopidogrel LD was 600 mg in 68% and 300 mg in 24% of cases and in-hospital maintenance dose (MD) was 75 mg in 98%. At time of hospital discharge, 92% of discharged patients were receiving clopidogrel (discharge dose 75 mg in all cases). QoL in discharged patients was good: median EQ-5D health state index at 0.85 (IQR 0.73–1.00). **CONCLUSIONS:** These real life data reflect treatment patterns among ACS patients managed by PCI in Germany in 2008–2009. Timing and place of antiplatelet loading differ between patients. The QoL of patients at discharge was high.

PCV134

THERAPEUTIC VERSUS ACTUAL MARKET SHARES FOR STATINS

Gorevski E, Bian B, Kelton C, Boone J, Guo JJ
University of Cincinnati, Cincinnati, OH, USA

OBJECTIVES: This study estimated market shares for six statins based on 1) the literature-determined lipid-lowering potential of the drugs, and 2) the distribution of U.S. adults depending on the amount of lipid-lowering they required. Estimated market shares were compared with actual market shares. **METHODS:** Two panels (1999–2000 and 2001–2002) from the National Health and Nutrition Examination Survey (NHANES) provided interview, demographic, and laboratory data for 3324 people >20 years of age who were not taking a statin. In accordance with the ATP III Guidelines, coronary heart disease (CHD) and CHD-risk-equivalent events including diabetes, other risk factors such as smoking and high blood pressure, and Framingham scores to obtain 10-year risk estimates were identified and calculated, respectively for each person, along with percentage LDL-C lowering required to reach his or her LDL-C goal. Depending on the amount of lowering needed and on whether the individual had a liver condition, hence, enhanced risk of rhabdomyolysis, a particular statin or particular statins with equal probabilities were assigned to the individual; e.g., a person without a liver condition requiring 50% lowering of LDL-C would be assigned rosuvastatin or atorvastatin, each with probability = 0.5. **RESULTS:** Of 1643 men surveyed, 57.88% were in the lowest-risk group (0–1 risk factors); 14.36% were in the highest-risk group (CHD or CHD-risk-equivalent). For the 1681 women, these percentages were 73.11% and 11.30%, respectively. Of people needing a statin, 73.74% needed LDL-C lowering by <25%; only 1.16% required LDL-C lowering of >60%. Therapeutic market shares were estimated at 20.11% (rosuvastatin); 18.94% (atorvastatin); 17.89% (simvastatin); 16.96% (lovastatin); 13.05% (fluvastatin); and 13.05% (pravastatin). **CONCLUSIONS:** Actual market shares are significantly different from market shares based on lipid-lowering considerations. Explanations include direct-to-consumer advertising; varying pricing strategies; and clinical trials for additional indications and subpopulations conducted only by the market leaders.

PCV135

CREATING AN EFFICIENT HOSPITAL PAYMENT SYSTEM

Baser O[1], Gust C[2]
[1]STATinMED Research/University of Michigan, Ann Arbor, MI, USA; [2]STATinMED Research, Ann Arbor, MI, USA

OBJECTIVES: By creating incentives around quality and efficiency, there exists consideration to bundle hospital and physician payments around the episodes of inpatient surgery. We provided current payments around surgical episodes including the degree to which different types of providers are involved. In particular, we looked at the most expensive procedure performed commonly on the elderly: coronary artery bypass graft (CABG) surgery. **METHODS:** The study was based on complete national U.S. claims data. Managed care patients were excluded (16% in 2005) from the study because service provided to them was not consistently captured in the data set. We also excluded patients who were less than 65 years of age or over 99, and those not enrolled in the data set at the time of their procedures (4%). Also excluded were patients who were nursing home residents before surgery. Patients undergoing CABG were identified using ICD-9 codes. Price-standardized payments from the date of admission for the index procedure to 30 days post-discharge were determined and categorized by payment type (hospital, physician, and post-acute care) and sub-type. **RESULTS:** The average total payment around an inpatient surgery episode was $45,358 for CABG. Hospital payments accounted for the largest of total payments (60% of the procedure), followed by physician payments (13%). Diagnosis-Related Group (DRG) payments and surgeon and anesthesia professional payments together accounted for 65% of total payments. Among payment types potentially leveraged by bundled payments, 30-day readmissions accounted for 10% of total payments around surgical episodes. Post-acute care, including home health care and extended care facilities, accounted for 7% of total payments. **CONCLUSIONS:** Payments for potentially mutable services, including outlier payments, 30-day readmissions, and post-acute care are considerable and might be reduced by incentives for hospitals and physicians to improve quality and efficiency.

PCV136

ATRIAL FIBRILLATION MANAGEMENT PATTERNS IN GREECE

Karampli E, Athanasakis K, Ollandezos M, Kyriopoulos J
National School of Public Health, Athens, Greece

OBJECTIVES: Construct the disease management model for patients with Atrial Fibrillation (AF) in Greece, according to initial therapeutic approach. **METHODS:** The analysis was based on data from patient records of 149 geographically distributed cardiologists, extracted via strictly structured questionnaire-based interviews. Partici-