and lipidosis were 3% to 22% and 26% to 10%, respectively. Use of other PAH-specific medication in this group of patients increased from 47% in 2007 to 69% in 2012. In the same group, the use of cardiovascular drugs also increased from 76% in 2007 to 91% in 2012. PAH-related costs ranged from $100,139 to $118,861 per patient. Other PAH-specific medications used in the study were non-parenteral PGI2, with 8% lower than non-parenteral costs. Mean (SD) PAH-related costs ranged from $189,763 ($167,329) during 2010 to $199,336 ($194,638) during 2012.

Conclusions: While overall use of PGI2 was constant over the five-year period, our findings suggest a shift towards a parenteral route of treatment. Our findings are consistent with the trend observed in other studies on the use of PAH-specific medications in the treatment of PAH, including the findings of other registries and observational studies.

PCV35 A RETROSPECTIVE CROSS-SECTIONAL STUDY ON THE PREVALENCE OF HYPERTENSION AND TREATMENT STATUS IN OBESE PATIENTS USING A HEART HEALTH CARE DATABASE

Tahane K1, Takahashi S2, Ii Y1, Kitazaki S1, Yamamoto Y1, Fujimoto Y1

OBJECTIVES: To assess the community setting of sociodemographic and economic outcomes of individuals with diabetes at very high cardiovascular (CV) risk (type 2 or type 1 diabetes, with target organ damage, such as microalbuminuria - ESC/ EAS Guidelines '11) and nondiabetic subjects (from 6 Local Health Units (ARNO Observatory, an administrative database containing data on hospitalizations, prescriptions and diagnostic/outpatient visit) during a time period of 1 year from 2007 to 2012. This research was supported by Provincial Secretariat for Science and Technological Development, Autonomous Province of Vojvodina project No 114-451-2458/2011 and by Ministry of Science, Republic of Serbia, project no 41012

PCV37 A ONE-YEAR FOLLOW-UP OF INDIVIDUALS WITH DIABETES AT VERY HIGH CV RISK TREATED WITH STATINS: OUTCOMES AND HEALTH CARE COSTS

Maggioni AP1, Rossi E2, Cinconze E2, Calabria S2

1ANMCO Research Center, Florence, Italy; 2CINEA Interuniversity Consortium, Casalino di Reno, Italy; 3CORE, Collaborative Outcome Research, Bologna, Italy

OBJECTIVES: To assess the community setting of sociodemographic and economic outcomes of individuals with diabetes at very high cardiovascular (CV) risk (type 2 or type 1 diabetes, with target organ damage, such as microalbuminuria - ESC/EAS Guidelines ‘11) and nondiabetic subjects (from 6 Local Health Units (ARNO Observatory, an administrative database containing data on hospitalizations, prescriptions and diagnostic/outpatient visit) during a time period of 1 year from 2007 to 2012. This research was supported by Provincial Secretariat for Science and Technological Development, Autonomous Province of Vojvodina project No 114-451-2458/2011 and by Ministry of Science, Republic of Serbia, project no 41012

PCV39 CHOICE OF ANTITHROMBOTIC DRUG IN NON-VALVULAR ATRIAL FIBRILLATION PATIENTS TREATED WITH RENAL REPLACEMENT THERAPY PRACTICE IN PRACTICE

Ciarletta A1, Cammarota S1, Creazzo S1, De Marinis C1, Izzo P1, La Bella G1, Piccilli F1, Romagnuolo F1, Esposito F1, Guida A1

1Linköping University, Linköping, Sweden; 2National Health Authority, Naples, Italy

OBJECTIVES: To assess the level of adherence to the guidelines for the prevention of thromboembolic risk in patients with Non-Valvular Atrial Fibrillation (NVAF). METHODS: A population-based cohort study was conducted using administrative data from 1,000,000 inhabitants from 6 Italian local health authorities (Campania Region, Italy, 1,000,000 inhabitants). NVAF was defined as one or more claims for atrial fibrillation (ICD-9-CM code 427.31) between July, 2013 and June, 2014 where none of the claims were associated with non-compliance, non-attendance or cardiotomy during the investigation period and there was no evidence of related valvular diagnoses or procedures. The cohort was classified according to the first drug dispensing during 6 months from the discharge date. Results: Among the NVAF group, 12.3% (28,295/2,290,491) were classified as high-risk (HR, score=3), high-risk (HR, score=2), moderate-risk (HR, score=1) or low-risk (HR, score=0). Multivariable logistic regression was used to evaluate the associations between ischaemic stroke and bleeding (HAS-BLED) risk with the choice of non-vitamin K antagonists oral anticoagulants (NOACs) versus vitamin K antagonists (VKA) therapy. RESULTS: A total of 1,936 patients was identified. 49% LR, 7.6% MR and 87.5% HR patients. Overall, 36.4% of patients were not treated (LR: 56.7%, MR: 55.0%, HR: 33.7%patients). Among patients treated, VKA in monotherapy was prescribed in 71.6% of cases (HR: 54.8%), aspirin in monotherapy to 27.5% (LR: 31.0%, MR: 34.3%, HR: 27.0%), NOAC in monotherapy to 19.3% (LR: 23.8%, MR: 17.9%, HR: 19.2%), other antiplatelet in monotherapy to 19.4% (LR: 16.7%, MR: 13.4%, HR: 19.8%), and associations to 7.1% (LR: 4.8%, MR: 5.7% and HR: 7.5%). The ischaemic stroke and bleeding risk were not significantly associated with the choice of anticoagulant drug. CONCLUSIONS: High proportion of NVAF patients with moderate or high stroke risk did not receive antithrombotic therapy as recommended by guidelines. Moreover, aspirin was very common in HR patients. The risk stratification did not influence the choice of anticoagulant drug.

PCV40 A RETROSPECTIVE, CROSS-SECTIONAL STUDY ON THE PREVALENCE OF HYPERTENSION AND TREATMENT STATUS IN OBESE PATIENTS USING A HEART HEALTH CARE DATABASE

Tanabe K1, Takahashi S2, Ii Y1, Kitazaki S1, Yamamoto Y1, Fujimoto Y1

1Pfizer Japan Inc, Tokyo, Japan, 2MinaCare co.ltd, Tokyo, Japan

OBJECTIVES: In Japan, real-world evidence regarding impact of obesity on the prevalence of hypertension is lacking. The objective of this study was to investigate the prevalence and treatment status of hypertension in obese patients, with a focus on resistant hypertension. METHODS: This was a retrospective study using a Japanese healthcare database composed of annual health checkup and claims data (Minicare Co Ltd.). Subjects aged 20-79 years at 2012 health checkup with 2011/2012 of checkups were selected for the study, Diagnosed hypertensive subjects (ICD-10 codes I10-I15, I17) who were prescribed with antihypertensive medications within 1 year prior to checkup were defined as “treated”. Resistant hypertension was defined as uncontrolled hypertension (SBP/DBP = 140/90mmHg) with 3 classes of antihypertensives including diuretics, or the use of a -4 classes. RESULTS: A total of 662,323 subjects (32% female, 68% male) were analyzed. The age category 40-49 years accounted for the largest proportion (35%) of the sample. The mean BMI was 21.8±3.7 and the proportion of obese subjects (BMI≥25) was 16.0±29.9% (female/male). Approximately 10% of the subjects were treated. For each age, sex, and treatment category, the prevalence of hypertension (defined as SBP/DBP = 140/90mmHg or “treated”) increased with increasing BMI. In particular, males in 40-49 age category, odds-ratio for the prevalence of hypertension versus BMI 18.5-25 were 0.601, 3.607, 7.405, 15.445 for BMI categories ≤18.5, 18.5-20.0, 20.0-24.0, >24.0 respectively. The prevalence of resistant hypertension among those diagnosed and prescribed with antihypertensives was consistently higher for obese subjects (vs non-obese) for each sex and age category; in particular, it was 6.6% vs 3.1% at BMI <25 and 6.0% vs 2.9% at BMI ≥25. The prevalence of resistant hypertension among those diagnosed and prescribed with antihypertensives was consistently higher for obese subjects (vs non-obese) for each sex and age category; in particular, it was 6.6% vs 3.1% at BMI <25 and 6.0% vs 2.9% at BMI ≥25. The prevalence of resistant hypertension among those diagnosed and prescribed with antihypertensives was consistently higher for obese subjects (vs non-obese) for each sex and age category; in particular, it was 6.6% vs 3.1% at BMI <25 and 6.0% vs 2.9% at BMI ≥25. The prevalence of resistant hypertension among those diagnosed and prescribed with antihypertensives was consistently higher for obese subjects (vs non-obese) for each sex and age category; in particular, it was 6.6% vs 3.1% at BMI <25 and 6.0% vs 2.9% at BMI ≥25. The prevalence of resistant hypertension among those diagnosed and prescribed with antihypertensives was consistently higher for obese subjects (vs non-obese) for each sex and age category; in particular, it was 6.6% vs 3.1% at BMI <25 and 6.0% vs 2.9% at BMI ≥25.