myocardial infarction (78% *versus* 68%; $P < 0.001$). Even after multivariate adjustment, MS was still associated with higher risk of in-hospital heart failure (odds ratio (OR), 1.37; 95% CI: 1.03–1.81; p = 0.028) and mortality (OR, 4.42; 95% CI: 1.25–15.5; p = 0.020). **CONCLUSIONS:** Prevalence of MS in ACS patients in Oman is high and seen more in females than in males. Furthermore, MS was associated with higher in-hospital heart failure and mortality.

PCV30

PREVALENCE AND CONTROL OF TRADITIONAL CARDIOVASCULAR RISK FACTORS AND ANTICIPATED AVOIDABLE CORONARY MORTALITY IN PRIMARY PREVENTION IN EUROPE: THE EURIKA STUDY

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OBJECTIVES: Despite the availability of the ESC European guidelines on cardiovascular prevention, considerable cardiovascular mortality remains throughout Europe. The European Study on Cardiovascular Risk Prevention and Management in Daily Practice (EURIKA) (NCT00882336) investigated the prevalence and degree of control of main cardiovascular risk factors in primary prevention of cardiovascular disease (CVD). **METHODS:** EURIKA was a cross-sectional study conducted simultaneously in 12 European countries (n = 809 primary care and specialist physicians). Patients aged ≥50 years who were free of clinical CVD, but had at least one risk factor as defined by the 2007 European guidelines on cardiovascular prevention, were eligible for inclusion. Data recorded included smoking status, body mass index, cholesterol levels, blood pressure and presence of diabetes. Cardiovascular risk was assessed by Systematic COronary Risk Evaluation (SCORE) methods. Attributable coronary mortality was calculated based on our prevalence estimates together with hazard ratios for CVD-related mortality (from the Third National Health and Nutrition Examination Survey). **RESULTS:** In total, 7641 patients (mean age: 65 years; 48% male) were evaluated. Of those aged <65 years, 27% had a SCORE-based absolute risk of CVD of ≥5%. The prevalence of risk factors was 21.3% for current smoking, 71.9% for hypertension, 55.4% for dyslipidemia, and 26.6% for diabetes. Control of risk factors among patients receiving therapy was 49% (between country range: 40–61%) for hypertension, 48% (26–74%) for dyslipidaemia and 40% (26–54%) for diabetes. The adjusted excess mortality attributable to risk factors was 17% (14–25%) for current smoking, 23% (21–25%) for hypertension, 26% (17–31%) for dyslipidaemia, and 30% (20–37%) for diabetes. **CONCLUSIONS:** The prevalence of traditional cardiovascular risk factors is high and their control is suboptimal. Traditional risk factors such as hypertension, dyslipidaemia and diabetes are responsible for a large fraction of the estimated coronary deaths that could be avoided through primary prevention.

PCV31

BLOOD PRESSURE CONTROL AND ANTIHYPERTENSIVE STRATEGY DIFFERENCES ACCORDING TO PATIENTS AGE

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OBJECTIVES: This study aims to determine the degree of blood pressure (BP) control and the differences in therapeutic strategies adopted by physicians based on patients' age and/or their functional status. **METHODS:** Multicenter and cross-sectional study that included patients with essential hypertension attending primary or specialist care, with at least one year of evolution. The study included 6453 patients, stratified into three main groups: a (<65 years) = 2184; B (65–79 years) = 2079; and C (≥80 years) = 2079. **RESULTS:** 51.3% of patients were male and mean (SD) age was 55.1 ± 7.5 years (group A), 71.4 ± 4.0 (B) and 83.7 ± 3.2 (C). 49.1% of patients were overweight. Mean systolic BP values were 141.3 ± 15.6 (A), 142.0 ± 16.3 (B) and 142.3 ± 16.8 (C) mmHg, and mean diastolic BP values were 84.5 ± 10.1 (A), 81.5 ± 10.5, 79.9 ± 11.2 (C) mmHg. 33.5% of patients had type 2 diabetes mellitus and 59.1% dyslipidemia. The existence of previous cardiovascular (CVD) or renal disease has been established in 38.9% of cases. The prevalence of CVD was 22.6% (A), 39.1% (B) and 55.9% (C). Target organ damage (TOD) was 26.7% (A), 40.8% (B) and 57.8% (C). The Barthel index that measures a person's daily functioning reflected that the oldest group had a significantly higher level of moderate or severe dependence ($P < 0.0001$). Patients with controlled BP were 29.4% (A), 25.5% (B) and 23.7% (C) ($P < 0.0001$). Clinical inertia—the failure to intensify therapy in patients who do not achieve the clinical objectives—reached 60.3% (A), 61.7% (B) and 66.2% (C) (p = 0.0002), respectively. Global treatment compliance was 94.3%, and the difficulty for taking the medication significantly increased with patients' age ($P < 0.0001$). **CONCLUSIONS:** Older hypertensive patients have a poorer BP control but an increased clinical inertia. These patients have higher prevalence of TOD and CVD, worse functional status and worse treatment compliance.

CARDIOVASCULAR DISORDERS – Cost Studies

PCV32

BUDGET IMPACT ANALYSIS OF PACLITAXEL DRUG ELUTING STENT (DES) FOR THE TREATMENT OF LOWER LIMB PERIPHERAL ARTERIAL DISEASE (PAD) IN FRANCE

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OBJECTIVES: The self-expandable paclitaxel DES represents a major development in endovascular treatments for lower limb PAD. Clinical data show improved clinical outcomes compared to bare metal stents (BMS). This budget impact analysis assessed the impact of introducing reimbursement for a paclitaxel DES in France. **METHODS:** An Excel-based model was developed to estimate the impact of a transition from BMS to DES over a 5-year horizon (15% in 2011 to 35% in 2015). Hospital episode statistics were used to estimate the 2011–2015 patient population. The analysis was conducted from the payer perspective and only direct costs of procedures were considered, based on GHM 2009 tariffs (stenting and revascularization) and LPPR tariffs (BMS and grafts). The main outcome was target lesion revascularization (TLR) in the superficial femoral artery (SFA) after primary stent placement: angioplasty, re-stenting, or bypass surgery. TLR rates were based on the paclitaxel drug-eluting SFA stent registry study and on BMS TLR rates reported in the literature (Years 1 and 2: 6% and 9% for the DES; 16% and 22% for average BMS) and extrapolated for years 3 to 5. Net budget impact was expressed as the difference in cost between the scenario where the DES is progressively adopted versus the status quo (patients treated with BMS only). **RESULTS:** The base-case results show an incremental cost of €278,526 in year 1, which is more than offset by increasing cost savings in all subsequent years (year 2: –€35,901; year 5: –€510,025), resulting in a cumulative 5-year net budget impact of –€727,649. One-way sensitivity analyses on key inputs continued to show cumulative 5-year cost savings. **CONCLUSIONS:** Reimbursement and consequent adoption of the paclitaxel DES would result in cost savings for the French health care payer, despite requiring an initial investment. This is due to savings associated with fewer SFA revascularization events after the primary intervention.

PCV33

ESTIMATING THE FINANCIAL IMPLICATIONS TO THE UK NHS OF INTRODUCING COREVALVE ALONGSIDE MEDICAL MANAGEMENT FOR THE TREATMENT OF SEVERE AORTIC STENOSIS

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OBJECTIVES: Aortic Stenosis (AS) is a severe cardiovascular condition and treatment often involves a major operation. For a subgroup of patients medical management (MM) is the only treatment option due to procedural risk. A transcatheter aortic valve implantation device "CoreValve," is less invasive and allows for the implantation of a replacement valve in this patient group. However, CoreValve is more expensive than MM and introducing this technology into routine care would lead to an increase in National Health Service (NHS) spending. We estimated this budgetary impact using existing economic models. **METHODS:** In an Excel based Markov model CoreValve was compared to MM for inoperable patients. Parameters were derived from published literature. Costs were taken from the most recent published sources. Decrements were applied to age-specific EQ-5D population norms to generate QALYs. Incidence estimates were derived from information in a large national database. Projected five year uptake rates were provided by Medtronic. The outputs from the economic model were used for all relevant parameters. Case mix estimates were elicited from a clinical advisory board. **RESULTS:** Across all patients, the estimated incidence rate of AS was 165 per million, 40% of these patients were assumed to be inoperable, 66 per million. The uptake rate of CoreValve in the inoperable group rose linearly from 0% to 50% over 5 years. When all inoperable patients were treated with MM the total budgetary cost was £13,454,000. When 50% of patients are treated with CoreValve and 50% with MM, the total budgetary cost increases to £49,706,000. Thus, the total burden to the NHS of 50% of inoperable patients receiving CoreValve would be £36,251,000. With a more optimistic five year uptake rate (75%) this increases to £54,852,000. **CONCLUSIONS:** Introducing CoreValve would result in an additional £36,251,000 being spent by the UK NHS.

PCV34

BUDGET IMPACT ANALYSIS OF PRIMARY TREATMENT OF HYPERTENSION WITH CANDESARTAN/HYDROCHLOROTHIAZIDE OR LOSARTAN/HYDROCHLOROTHIAZIDE IN THE MEXICAN SOCIAL SECURITY INSTITUTE

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OBJECTIVES: To calculate and compare costs of primary treatment of hypertension with candesartan/hydrochlorothiazide (HCT) or losartan/HCT in the Mexican Social Security Institute (IMSS). **METHODS:** An adaptation from Kjeldsen observational study of 14,100 patients diagnosed with hypertension and the costs' sub analysis of Henriksson was made to have an approximation of incurred costs by IMSS when using candesartan/HCT or losartan/HCT in the primary hypertension treatment and its impact in reducing related cardiovascular events. First assumption for adaptation was to use only costs of combined therapies with HCT since monotherapies are not included in the IMSS formulary. Hospitalizations, laboratory tests and physician visits resource consumption reported by Kjeldsen were multiplied by IMSS 2010 unit costs.