patients who begin with low and high levels and regardless of final level achieved. METHODS: A cohort of 27,660 patients with coronary artery disease, peripheral vascular disease, or diabetes mellitus were selected and followed retrospectively for their first myocardial infarction or revascularization recorded in the New England Veterans Affairs database. Pre-outcome low-density lipoprotein cholesterol reduction was categorized as follows: <10 mg/dL, reference; 10–39 mg/dL, small reduction; 40–69 mg/dL, moderate reduction; >70 mg/dL, large reduction. Cox proportional hazards was used to determine hazard ratios for each category of lipid reduction compared to reference and stratified by high or low initial LDL-C, adjusting for initial LDL-C, statin use, age, gender, and co morbidities. RESULTS: Among patients with initial LDL-C above the median of 133 mg/dL, hazard ratios (95% confidence intervals) for small, moderate, and large reductions compared to reference were 0.90 (0.85–0.96), 0.84 (0.79–0.90), and 0.76 (0.70–0.83) respectively. A total of 3448 or 24% of such patients achieved a final level <100 mg/dL. Among patients with initial levels below the median, hazard ratios (95% confidence intervals) for small, moderate, and large reductions were 0.90 (0.85–0.96), 0.87 (0.79–0.96), and 0.76 (0.56–1.05) respectively. A total of 5492 or 40% of such patients achieved final level <100 mg/dL. CONCLUSION: These data suggest that magnitude of reduction in low-density lipoprotein cholesterol is proportional to degree of reduction in cardiovascular risk, and that this effect holds both for patients with initially low or high lipid levels, regardless of whether a final LDL-C of <100 mg/dL was achieved.
uncontrolled BP or TC was 46.4% and 48.7%, respectively. The correction of the logistic model demonstrated the association of CVD with male sex (OR = 2.6), diabetes (OR = 2.2), dyslipidemia (OR = 1.6), BP (OR = 1.31) and age (OR = 1.1), p < 0.05.

CONCLUSIONS: Therapeutic control goals in primary care setting might be improved. It would be necessary to make new representative studies showing the degree of control of our patients in daily clinical practice.

PCV17
PROJECTED IMPACT ON CORONARY HEART DISEASE OF ADDING PROLONGED-RELEASE NICOTINIC ACID (NIASPAN®) TO STATIN TREATMENT IN EUROPEAN PATIENTS WITH TYPE 2 DIABETES
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OBJECTIVES: A recent Pan-European Survey highlighted a prevalence of low High Density Lipoprotein-cholesterol (HDL-c <1.03 mmol/L in men and <1.29 mmol/L in women) in over 30% of patients diagnosed with dyslipidemia, irrespective of statin treatment. In order to help physicians focus their attention on this risk factor, a model was used to project clinical benefits on coronary heart disease (CHD) endpoints of raising HDL-c by adding Niaspan® to statin therapy in Type 2 Diabetes (T2D) patients.

METHODS: A computer model simulated the clinical benefit of combination therapy statin + Niaspan®; the first sub-model (Monte-Carlo simulation) generated a cohort using patient characteristics from the Pan-European Survey (diabetic sub-group) and applied Niaspan® treatment effect (European SPC, 2g/day); the second sub-model (Markov) estimated the long-term clinical outcomes associated with patient’s lipid changes (Framingham risk equations). Simulations were run to capture 5, 10 years and patients’ lifetimes.

RESULTS: In these patients, mean life expectancies of 19.42 years and 18.78 years were projected for the statin + Niaspan® and statin monotherapy arms respectively (difference of 0.64 years). The addition of Niaspan® to statin treatment was associated with a lower cumulative incidence of CHD events than statin monotherapy at different time horizons leading to absolute risk reductions of 14.1% for myocardial infarction and 5.5% for CHD death.

CONCLUSIONS: Due to its positive effect on HDL-c levels, the addition of Niaspan® to statin treatment was projected to reduce the cumulative incidence of CHD events compared to statin monotherapy in a European T2D patient population with persistently low HDL-c.

PCV19
DISCONTINUED USE OF MYCOPHENOLATE MOFETIL AND GRAFT LOSS IN HEART TRANSPLANT RECIPIENTS
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OBJECTIVES: Changing patterns of immunosuppression use have been associated with increased risk of adverse graft and patient survival outcomes. This study aimed to assess the relationship between discontinuing use of mycophenolate mofetil (MMF) on two-year graft loss and two-year patient death.

METHODS: US claims data from commercial health plans for 396 patients receiving heart transplants (1995–2005) were linked to data from the Organ Procurement Transplant Network (OPTN). Transplant recipients were grouped into two: those who continued and those who discontinued (MMF DC) using MMF. MMF use was defined as having 21 pharmacy claim posts-transplant for the medication. Discontinuation was defined as more than a 30 day gap in MMF coverage followed by no subsequent refills during the year following the initial MMF script. Cox proportional hazards analysis was used to estimate the risk of discontinuating MMF on graft loss and dying. RESULTS: Thirteen percent (N = 52) of the study population was in the MMF DC group. The majority of the population was between age 41 and 60 (57%), male (78%), transplanted between 1996–2000 (44%), and received a medication for a gastrointestinal condition during the year following their initial MMF script. Cox proportional hazards analysis was used to estimate the risk of discontinuing MMF on graft loss and dying. RESULTS: Thirteen percent (N = 52) of the study population was in the MMF DC group. The majority of the population was between age 41 and 60 (57%), male (78%), transplanted between 1996–2000 (44%), and received a medication for a gastrointestinal condition during the year following their initial MMF script.

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CONCLUSIONS: Disrupting the pattern of MMF use was related to a significant increase in the risk of graft loss and death during two years post transplant in this heart transplant recipient population covered by commercial health plans. Future work should examine whether these findings extend to heart transplant recipients covered by other types of insurance and potential causes of therapy discontinuation.

PCV18
OUTCOME OF THIAZOLIDINEDIONE USE IN DISCHARGED DIABETIC PATIENTS WHO WERE HOSPITALIZED FOR HEART FAILURE
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OBJECTIVES: Thiazolidinedione (TZD) was recommended not for patients with moderate and serious heart failures due to the adverse reaction of body fluid retention. Our study investigated the use of TZD by type 2 diabetic patients after they were discharged from hospitalizations for heart failure. METHODS: The cohort observation was based on claims database of Taiwan’s National Health Insurance (NHI) for 2002–2004. There were 4774 diabetic patients who were hospitalized due to heart failure during 2003: 379 TZD users and 4395 non-TZD users. A total of 2692 non-TZD users who used sulfonylurea after discharge were selected as the control group. Cox proportional hazard models were estimated to compared the outcomes of death and readmission to hospitals of TZD users and sulfonylurea users, one year after the time patients were discharged. RESULTS: There were 7.9% of diabetic patients who were hospitalized for heart failure and received TZD treatments. There was no significant difference on readmission over one year after discharge between the two groups. However, among those who used TZD or sulfonylurea less than 60 days, those who used TZD had lower HR of readmission than those who used sulfonylurea (HR 0.728, 95% CI 0.551–0.962). Overall, the HR for death among patients receiving TZD was significant lower than the control group of sulfonylurea users (HR 0.092, 95% CI = 0.022–0.380).

CONCLUSIONS: Based on the precautions stated in TZD package inserts, 7.9% of type 2 diabetic patients with heart failure received potentially inappropriate prescriptions. Short term use of TZD significantly reduced hazards ratio in readmission, though long term use of both TZD and sulfonylurea showed no difference on readmission, and the use of TZD significantly reduced the hazard of death.