are complementary technologies. METHODS: We extracted data for 5016 PCI patients with DES or non-DES, admitted between April 24 and June 30, 2003 from the Solucient, LLC ACTracker database—a proprietary database with detailed drug information. Patients were identified as having received a GPIIb/IIIa inhibitor if they received any of the following drugs: abciximab, tirofiban, or eptifibatide. The likelihood of a patient with a DES receiving a GPIIb/IIIa inhibitor was modeled using a logistic regression equation, adjusting for hospital and demographic characteristics, as well as whether the patient had an acute myocardial infarction (AMI). RESULTS: Patients undergoing PCI with a DES were less likely than those undergoing PCI with a non-DES to receive a GPIIb/IIIa inhibitor. However, the results were not statistically significant. (OR = 0.917, 95% CI 0.793, 1.061). CONCLUSIONS: Data from the time period just after approval of drug-eluting stents does not show any statistically significant difference between use of GPIIb/IIIa inhibitors among PCI patients receiving DES and non-DES. However, the lower use of GPIIb/IIIa inhibitors among DES patients in our study may prove to be significant once data from additional PCI patients becomes available.

**PCV59**

**CLINICAL PHARMACIST INVOLVEMENT IN COMMUNITY ANTICOAGULATION CONTROL**

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Many patients are chronically treated with oral anticoagulants to prevent thromboembolic events. These medications are life saving but have a narrow therapeutic window, which can expose these patients to life threatening events if the International Normalized Ratio (INR) is not kept within the therapeutic window. High potential of drug-drug and drug-food interactions adds to the complexity of achieving good anticoagulation control, and knowledge of these interactions can assist in making better therapeutic decisions. OBJECTIVE: To evaluate the impact of clinical pharmacist intervention on anticoagulation control in chronic patients. METHODS: Thirty-seven chronic patients with uncontrolled anticoagulation were randomly identified from the data systems of Maccabi Health care Services. The clinical pharmacist intervention consisted of meeting the family practitioners in order to go over patient clinical charts, and sending written recommendations regarding anticoagulation control. Some of the patients were also invited to a personal meeting with the clinical pharmacist for pharmaceutical guidance, and were closely followed throughout the process. Outcome analysis was based on comparison of the last two INR results before and after the clinical pharmacist intervention, according to target INRs, matching the specific indication for anticoagulant therapy. RESULTS: Following the clinical pharmacist intervention we observed a two-fold increase in the number of patients with anticoagulation control: a 2.5 fold increase in the number of patients with anticoagulation control in the optimal range (INR between 2–3 for most of the indications and 3–4 for mechanical valve replacement), and a 1.8 fold increase in the number of patients with anticoagulation control in the tolerable range (INR between 1.8–4 for most of the indications and 2–4.25 for mechanical valve replacement). These differences were statistically significant (p = 0.018). CONCLUSION: These findings indicate that chronic patient’s anticoagulation control strongly benefits from clinical pharmacist intervention. Further study is required to control for spontaneous patient improvement.

**DISORDERS OF LIPOID METABOLISM: LIKELIHOOD OF PRESCRIPTION THERAPY**

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OBJECTIVES: Individuals with hyperlipidemia are at risk for CHD, hypertension and diabetes. This study examined the likelihood of receiving prescription therapy based on patient diagnoses, demographics and other factors. METHODS: The study design was retrospective covering January 2000–December 2002. It encompassed 15,000 electronic medical records from primary care practices in eight States. Patients with lipid disorders were identified by ICD-9 diagnoses. Treatment patterns and laboratory data were evaluated vs. NCEP ATP III Guidelines. RESULTS: On average, 23.4% of patients eligible for treatment according to the Guidelines were prescribed cholesterol lowering drugs. Of those, 40.5% of patients (95% CI 39.6–41.3%) had prescription therapy without a hyperlipidemia diagnosis. In each of these cases, one or more co-morbid diagnoses for CHD risk were present. The likelihood of treatment for patients <45 years was 1.37 times lower (p < 0.001) than older patients in the “official” risk age for CHD (55–64 years). The probability of treatment for men was higher than for women (OR 1.11 p < 0.01). There was no significant difference in treatment frequency for Caucasians vs. blacks. The likelihood of treatment for patients with documented hyperlipidemia was 3.86 times higher than for those without a diagnosis (p < 0.0001). The likelihood of treatment for patients with CHD was 1.6 times higher (1.59–1.89) than for patients without. CONCLUSIONS: In patients diagnosed with lipid disorders and at risk for CHD, the use of cholesterol lowering medication appears to be relatively low compared to that recommended by the NCEP ATP III Guidelines. In those patients who are prescribed cholesterol lowering medication without documented hyperlipidemia, the presence of CHD risk factors appear to be a major consideration. Possible reasons for a relatively low level of prescribing include undocumented treatment by life style changes, lack of awareness of NCEP guidelines by physicians, economic constraints, and/or other factors.

**DIABETES (including Parathyroid Disease)**

**DIABETES (including Parathyroid Disease) — Clinical Outcomes Studies**

**PCV60**

**LOWER INCIDENCE OF MICROVASCULAR EVENTS ASSOCIATED WITH PIOGLITAZONE MONOTHERAPY THAN INSULIN MONOTHERAPY IN PATIENTS WITH TYPE 2 DIABETES: A RETROSPECTIVE PROPENSITY SCORE MATCHED COHORT ANALYSIS**

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OBJECTIVE: To examine the microvascular risk associated with use of pioglitazone monotherapy versus insulin monotherapy in type 2 diabetes patients by retrospective analysis of the GE Medical Systems (GEMS) clinical database. METHODS: Patients ≥18 years of age with a diagnosis of type 2 diabetes mellitus were included if on active treatment after 1999, and if no microvascular events (one or more of neuropathy, nephropathy, or retinopathy) were present at baseline. Only patients who were initiated with pioglitazone or insulin as monotherapy were