to optimize the managed entry of new drugs in the future through an iterative process. This includes guidance for all key groups on future activities to achieve this.

Results: There have been multiple demand-side activities among countries to manage the utilization of dabigatran. This included extensive prelaunch activities, risk-sharing arrangements, prescribing restrictions, and monitoring of prescribing postlaunch against agreed guidance. Clinical pharmacologists played a key role in a number of countries. Reimbursement was denied in some countries due to concerns with its budget impact and/or issues with excessive bleeding. Development of a new model and future guidance was proposed to better manage the entry of new drugs in the future, centring on 3 pillars of pre-, peri-, and postlaunch activities. This was accompanied by guidance to all key stakeholder groups, including health authorities, physicians, patients, and pharmaceutical companies on suggested activities pre- to postlaunch to reduce the likelihood of new drugs being withdrawn as well as enhance their chances of funding. This included guidance on key considerations that authorities should consider when evaluating risk-sharing arrangements or developing patient registries.

Conclusion: Models for introducing new drugs are essential to optimize their prescribing especially where there are concerns. As a result, promote high prescribing standards postlaunch. Without such models, new drugs may be withdrawn prematurely and/or struggle for funding.

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PP084—A EUROPEAN SCORE PREDICTS BETTER SOUTH AMERICAN CARDIOVASCULAR RISK THAN FRAMINGHAM RISK EQUATIONS

I. Marchant1*; and F. Gueyffier2
1Preclinical Sciences, Medical School University of Valparaiso, Valparaiso, Chile; and 2CNRS, UMR 5558, Laboratoire de Biométrie et Biologie Evolutive, Service de Pharmacologie Clinique et Essais Thérapeutiques, Université Lyon 1, Lyon, France

Introduction: The sustained increase of cardiovascular disease in the developing world is a truly challenge. While > 80% of all CVD deaths occur in developing countries, the lack of longitudinal studies hinders the extrapolation of international recommendations for CVD prevention to a given country in the absence of risk predictors developed from local epidemiologic data. A risk estimation system has been developed by adapting the Framingham equations published in 1998 using local information to predict overall CHD risk in the Chilean population assuming a constant odds ratio for the risk factors between populations. The predictive power of the Chilean risk estimator has not been assessed. We explored the validity of prediction by the Chilean risk equations against the CHD events observed in the Chilean population.

Patients (or Materials) and Methods: We performed a simulation study to compare the predicted events in a Realistic Virtual Population (RVP) to the events observed in the Chilean population over 10 years. The RVP represents 10% of Chilean adults aged 35 to 79 years with the CVD risk profiles reported by the National Health Survey of 2003. We derived the 10-year rates of CHD fatal and nonfatal from the individual risks by age and gender categories. We obtained the 10-year rates observed by extrapolating the latest annual incidence rates of fatal CHD and hospital discharges after nonfatal CHD from national statistics using the life tables method. We performed predicted-observed comparisons for the Chilean-adapted Framingham equations, the Framingham equations developed by Anderson et al, and the SCORE equations estimates.

Results: The overall CHD events were overestimated by the Chilean risk equations in men and women < 55 years and underestimated in individuals of both genders older than 55 years. The calibration defaults were greater in women compared with men in all age categories. The overestimation of CHD with the Framingham model used as a reference was maximal in the second age category for both genders. The CHD fatal events were underestimated by SCORE in men and women at all ages although the age-related risk gradient was closer to the observed gradient compared with Framingham’s predictions.

Conclusion: The contribution of risk factors to CHD risk appears to be different in the Chilean population compared with the US population. Overall, SCORE showed improved performance to predict Chilean CHD deaths.

Disclosure of Interest: None declared.

PP086—USAGE OF ANTIHYPERTENSIVE DRUGS IN SERBIA: AGE AND GENDER STRATIFICATION

A. Tomas*; O. Horvat; Z. Tomić; M. Ban; and A. Sabo
Department of Pharmacology, Toxicology and Clinical Pharmacology, Faculty of Medicine, University of Novi Sad, Novi Sad, Serbia

Introduction: Arterial hypertension represents a major cause of cardiovascular morbidity and mortality in the city of Novi Sad, Serbia, with every fourth adult inhabitant suffering from it. The aim of this study was to analyze patterns of antihypertensives usage within different age groups of patients (30–40, 50–60, 70–80 years) and between genders.

Patients (or Materials) and Methods: The study was conducted in Novi Sad (estimated population 350,000) from September 2011 to February 2012. The data about antihypertensives issued on prescription were collected from state-owned pharmacies in Novi Sad. Consumption was calculated using the ATC/DDD methodology, and results were expressed in DDD/1000 inhabitants/d.

Results: The total use of antihypertensives issued on prescription in Novi Sad was 282,6 DDD/1000 inhabitants/d. ACE inhibitors were the most frequently used antihypertensives in all age groups. Higher usage of beta-blockers in age group 30 to 40 years compared with other age groups was shown. Diuretics and calcium antagonists were more frequently prescribed to patients in age groups 50 to 60 and 70 to 80. Most commonly prescribed antihypertensive drug in age group 30 to 40 was enalapril, in contrast to amlodipin, the most commonly prescribed antihypertensive in age groups 50 to 60 and 70 to 80. The consumption of angiotensin receptor antagonists was low (<3%) within all age groups. Women accounted for 59.9% of total consumption of antihypertensives. Only in age group of 30 to 40 years, more antihypertensives were prescribed to men (62.9%) while in the age groups 50–60 and 70–80, the usage of antihypertensives was significantly higher in women. Beta-blockers were more commonly used in women than in men, while for other groups of antihypertensives, no difference in usage was observed between male and female patients.

Conclusion: Widespread usage of ACE inhibitors, and low usage of other antihypertensives, especially diuretics, points to therapeutic irrationalities. The most cost-effective drugs — diuretics — accounted for only 4% of total consumption. High usage of more expensive antihypertensive agents presents a financial challenge for health care system.

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