ficiency or reinfarction were present in 46.8% of patients. Mean homocysteine levels in patients with and without early complications were 22.99±19.01 and 17.93±7.08 µmol/l, p=0.018. The unadjusted hazard ratio of homocysteine level > 12µmol/l was 2.4, IC95% [1.04-5.65]. Cox proportional hazards model showed that plasma homocysteine was not an independent correlate of inhospital complications (Hazard ratio=1.43, IC95% [0.37-5.53], p=0.6). The mean follow-up period after discharge was 17.2 months [12 – 28.8 months], 43.2% of patients presented a late complication: death, cardiac insufficiency or myocardial infarction. Homocysteine wasn’t significantly correlated with late complications (mean levels in patients with and without late complications: 18.67±5.99 and 20.19±13.07µmol/l, p=0.43).

**Conclusion:** Homocysteine levels measured in the acute phase of STEMI are correlated only with early but not late outcome and it isn’t an independent predictor of inhospital major cardiovascular major complications.

### 077

**Management of high cardiovascular risk patients treated with statins in France**

Jean Dallongeville (1), Florence Thomas-Delecourt (2), François Morand (3)

(1) Institut Pasteur de Lille, Lille, France – (2) AstraZeneca, Rueil-Malmaison Cedex, France – (3) Cegedim Strategic Data, Boulogne-Billancourt, France

**Purpose:** The objective of this study was to describe utilisation of newly prescribed statins in French primary care.

<table>
<thead>
<tr>
<th>LDL-cholesterol target</th>
<th>High Risk N=520</th>
<th>≥3 RF N=55</th>
<th>2 RF N=204</th>
<th>1 RF N=213</th>
<th>0 RF N=118</th>
<th>Total N=1110</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion achieving LDL goals</td>
<td>33.3%</td>
<td>47.3%</td>
<td>69.6%</td>
<td>85.0%</td>
<td>94.9%</td>
<td>57.1%</td>
</tr>
</tbody>
</table>

**Methods:** From February 2008 to July 2009, 272 French general practitio-
ners (GPs) included 2122 patients treated with a new statin, out of which 670 were treated with rosuvastatin. For each patient, demographic characteristics, comorbidities, concomitant drug and biological characteristics were docu-
mented.

**Results:** The mean patient age was 62.6 and there were slightly more men (54.6%) than women. The main cardiovascular risk factors (RF) were: hypertension (50.3%), diabetes (22.7%), family history of premature cardiovascular disease (22.5%) and smoking (17.4%). Nearly 3 GPs out of 4 declared they provide life-style and nutritional advice before initiating the treatment : only 44.5% gave diet booklets. GPs are the main first-time statins prescribers (88.9%) in France. This percentage was higher for rosuvastatin than for the others statins (93.2% vs. 86.8% ; p<0.001). Two thirds of the patients received a statin for the first time following the diagnosis of dyslipidemia. One third was switched to a new statin. The reasons for the switch were related to lack of effectiveness of previous treatment and to intolerance to previous statins (mainly muscle weakness or pain). Before initiating treatment, biochemical analysis was performed in 91% of patients. And 3 to 6 months after statin ini-
tiation, lipid levels, transaminase levels and CPK were measured in 67%, 40% and 28% of all patients, respectively. At that time, 57.1% of patients reached the LDL-cholesterol according to risk categories distribution. The proportion of patients reaching the target was higher in the rosuvastatin group than in the others statins group (62.3% vs. 54.6% ; p=0.016). Overall, the achievement of LDL-cholesterol targets was lower in patients with higher CV risk (Table).

**Conclusions:** In real-life conditions, LDL treatment targets are reached in less than 2/3 of patients treated with statin. Achievement of LDL targets is less frequent in patients at high cardiovascular risk leaving much room for improvement.