patients with no episodes (HR 7.5, 95% CI 2.6, 22.0; p < 0.01). CONCLUSIONS: Upper GI symptoms were significantly associated with poor adherence to and discontinuation of low-dose ASA. Strategies to help patients continue with low-dose ASA cardioprotection are warranted.

DIFFERENCES IN PERSISTENCE BETWEEN CCBs WHEN COMBINED WITH AN A2RA OR AN ACE ANTIHYPERTENSIVE IN AUSTRALIA

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OBJECTIVES: To assess persistence to the combinations of dihydropyridine (DHP) calcium-channel blockers (CCBs) with an Angiotensin Converting Enzyme (ACE) inhibitors or an Angiotensin II Receptor Antagonist (A2RA), using PMS claims data provided by Medicare Australia. METHODS: This analysis is based on all scripts supplied to a one in ten sample of the Australian population drawn from de-identified Pharmaceutical Benefits payment records from January 2003 to December 2006. Initiation occurred with 2 consecutive months of an A2RA or an ACE combined with a DHP following at least 6 months without a DHP combination. Treatment cessation was 3 consecutive months of none or just one of the drugs making up the combination. Hazard ratios (HR) were derived and adjusted for patient age/sex and initiating specialty. RESULTS: More than 17,500 Concessional patients, initiated on a DHP combined with an A2RA and more than 12,000 Concessionals patients, initiated on a DHP combined with an ACE, had their persistence to the combination assessed. More than persistence (70%). CI) differed between DHP combinations: Lercanidipine/A2RA 23 months [22–25], Felodipine/A2RA 20 months [18–22], Nifedipine/A2RA 17 months [16–18], and Amlodipine/A2RA 14 months [13–15]. Using Lercanidipine/ A2RA as the reference (HR = 1.00), patients were significantly more likely to cease the combination: Felodipine/A2RA (8.7%), Nifedipine/A2RA (18.5%), and Amlodipine/A2RA (33.9%). Lercanidipine/ACE 24 months [22–26], felodipine/ACE 21 months [19–24], nifedipine/ACE 16 months [14–18], and amlodipine/ACE 15 months [14–17]. Using Lercanidipine/ACE as the reference (HR = 1.00), patients were more likely to cease the other combinations felodipine/ACE (7.2%), nifedipine/ACE (24.8%), and amlodipine/ACE (26.8%). CONCLUSIONS: In terms of optimal treatment persistence, lercanidipine seems to be the best DHP to combine with an A2RA or an ACE, while amlodipine seems to be the worst DHP to combine with an A2RA or an ACE.

PREDICTORS OF NON-PERSISTENCE ON STATIN TREATMENTS IN ITALY: A RETROSPECTIVE STUDY

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OBJECTIVES: To identify enhancing factors of the medication adherence using the data from a randomized trial of patients with chronic heart diseases. METHODS: We used the data from a randomized trial involving a total of 6967 patients with chronic heart diseases. This trial followed up them with an average of 5 years. Adherence rate was obtained by the division of a number of days to take a targeted medicine by 365 days each year for each patient. The targeted medicine was the one assigned by randomization. An overall adherence rate for each patient was defined by an average of annual adherence rates during the follow-up period. Good medication adherence was defined by the overall adherence rate of 80% or more. An adjusted odds ratio (OR) was calculated in order to identify factors of adherence. RESULTS: The mean of 39.43. Subjects that reported having a health problem in the last month had significantly less VAS than those who did not 70.66 vs 80.30. VAS was significantly related to cardiovascular risks factors (high blood pressure, high-cholesterol, over-weight, high glycaemia, low physical activity) except smoking. VAS was significantly lower in females, in the elderly, in subjects with less education, lower household income, and unemployed. CONCLUSIONS: VAS showed expected relations with the SDC variables, with General Health, and in general, it showed to behave as expected with the presence of cardiovascular risk factors with the exception of smoking. This is one of the few general population surveys in Latin America that incorporated the EQ-SD tool to describe population health status.

PREFERENCES OF PATIENTS, PHYSICIANS AND CAREGIVERS IN THE CHOICE OF ABDOMINAL AORTIC ANEURYSM TREATMENT OPTIONS: THE PREFER STUDY

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OBJECTIVES: Factors influencing preferences towards type of abdominal aortic aneurysm (AAA) have been scarcely investigated. The objective was to identify characteristics important for physicians, patients and their caregivers in the treatment of AAA. METHODS: We conducted a Discrete Choice Study involving AAA patients, their caregivers and experienced vascular surgeons. Participants self-completed questionnaires including 4-8 choice sets comparing pairs of options obtained from a factorial combination of 6 characteristics previously selected during a focus group and pilot study: type of anaesthesia (general vs. local); recovery time to everyday basic activities; risk of recurrence; duration of treatment; the number of hospital days; and possible complications. RESULTS: The final sample included 2382 patients (28.4% female). The final sample included 2382 patients (28.4% female). The final sample included 2382 patients (28.4% female). Only 23.2% of patients persisted for 3 years of therapy. Female gender and absence of diabetes comorbidity were the most significant predictors of early discontinuation. CONCLUSIONS: Further studies are required to evaluate whether these factors are related to persistence to treatment.