(P < 0.0002, chi-square; range from 0.5 to 6.6 events per 100 patient years) confirming significant heterogeneity in the results. In the assembled cohort of 3998 patients there were 174 admissions in 6 months, of which 117 included some evidence of warfarin related bleeding. Applying the criteria from the 12 different studies resulted in a range of 24 to 117 of these events being classified as “major bleeds”. The 3 studies with most restrictive definitions reported from 0.5 to 1.1 events per 100 patient years, compared with from 1.5 to 2.8 events per 100 patient years for the 4 studies with least restrictive definitions. CONCLUSIONS: It is essential for future outcomes research in anticoagulant therapy that consistent definitions of major adverse outcomes are applied. The inconsistent definitions used in the 12 published studies reviewed make it impossible to assess the impact of other differences between studies, for example in INR range or % of time within range.

**EFFECTIVENESS OF CLINICAL PATHWAYS FOR PATIENTS WITH HEART FAILURE**
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OBJECTIVES: To evaluate the effectiveness of the care provided to patients with heart failure through the implementation of clinical pathways at the hospital “The Holy Family” in Novafeltria (Italy). METHODS: We performed a pre-post analysis model to evaluate the effect of the application of clinical pathways on process indicators, outcome indicators and on the costs sustained to treat the patients. We compared the results obtained treating the patients according to the clinical pathway with the results obtained before implementing the pathway. We studied quantitative variables with t Student test or Wilcoxon test, qualitative variables with X2 test. RESULTS: Two hundred forty-six cases were included in our study. These subjects were all the patients admitted for heart failure to the hospital and treated by the staff. We compared the age, the sex and the disease staging (NYHA scores at admission) of the patients of the 2 groups and we did not find any significant difference. After the implementation of the pathway we observed a significant improvement of the core processes. We observed a reduction of the rate unscheduled readmissions within 31 days from discharge (from 6.74% to 2.94%; p > 0.05), of the average length of stay (from 10.89 days to 7.86; p < 0.05) and of inpatients’ mortality (from 17.42% to 4.41%; p < 0.01). The average costs for patient increased from 2.399 US$ to 2.596 US$ (p > 0.05). CONCLUSION: Our primary finding was that the implementation of the clinical pathway for heart failure improved patients’ outcomes and the quality of the core processes. Our results also showed that this was possible without incrementing the costs. This study has important limitations too. The initial measurement occurred a year before the full implementation of the pathways. Thus, it is possible that some of the observed improvement represented a natural drift toward higher performance.

**ACHIEVEMENT OF THE EUROPEAN ATHEROSCLEROSIS SOCIETY LDL-C TARGET BY HYPERCHOLESTEROLAEMIC PATIENTS RECEIVING ROSUVASTATIN COMPARED TO ATORVASTATIN, PRAVASTATIN OR SIMVASTATIN: AN EVIDENCE-BASED MEDICINE APPROACH**
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OBJECTIVE: To determine the number needed to treat (NNT) for one additional patient to achieve the European Atherosclerosis Society (EAS) target for LDL-C of <3 mmol/L at 12 weeks for rosuvastatin compared to atorvastatin, pravastatin or simvastatin. Patients included in the clinical trials comparing rosuvastatin with atorvastatin, pravastatin and simvastatin had an initial LDL-C ≥160 (4.1mmol/L) and <250mg/dL (6.5mmol/L). METHODS: The rosuvastatin trials were specifically designed to allow pooling of the data to provide summary estimates of efficacy. This design strategy minimised the potential bias caused when pooling results by variation in the event rates, differences in the outcomes considered, effects of secular trends on disease risk, and differences in clinical setting. The pooled efficacy data was used as the basis for the calculation of the NNTs. RESULTS: Rosuvastatin 10mg is more effective at lowering LDL-C to the EAS target than atorvastatin 10mg, pravastatin 20mg and simvastatin 20mg at 12 weeks and this translates into relatively small NNTs. By convention, NNTs are rounded up to the nearest whole number of patients. Rosuvastatin 10mg has an NNT of 4 compared to atorvastatin 10mg, 2 compared to pravastatin 20mg, and 4 compared to simvastatin 20mg (p < 0.001, all comparisons). CONCLUSIONS: As a general rule, an NNT of 6 or less might be considered “good” for an acute treatment, while an NNT as large as 40 might be considered “good” for a chronic treatment (depending on the duration of treatment and the severity of outcome). In this context, an NNT of 4 for rosuvastatin 10mg compared to the next best in class (atorvastatin 10mg) would be considered a very favourable result.

**ENOXAPARIN USE IN PATIENTS WITH MECHANICAL HEART VALVES REQUIRING BRIDGING THERAPY FOR SUBTHERAPEUTIC CHRONIC ORAL ANTICOAGULATION**
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OBJECTIVES: Enoxaparin has been used for thromboprophylaxis (TBX) when patients with mechanical heart valves require bridging therapy for sub-therapeutic chronic oral anticoagulation (COA). Due to recent