plan in US covering 4 million lives. Outcomes were measure any occurrence of CV including ischemic heart disease, cerebrovascular disease, and peripheral vascular disease. A multicentric logistic model was developed to evaluate adjusted CV-risk. Multicollinearity test and Hosmer-Lemeshow test were performed. RESULTS: Mean (SD) age was 75(±9) years in combo-group(N = 53) and 77(±7) years in mono-group(N = 5670). In combo-group, mean(+/− SD) treatment duration was 779(+/−424) days for statin+fibrate combination-therapy. In mono-group, mean(+/− SD) treatment duration was 987(+/−388) days for statin-only monotherapy. Unadjusted CV-rates of combo-group versus mono-group were not significantly different (odds ratio [OR] = 1.39, P = 0.2311). Although adjusting for age, gender, prior CV, CV related pharmacy-costs, total medical-costs, diabetes with complication, and Elixhauser-comorbidity, CV-rates of combo-group versus mono-group were not significantly different (OR = 1.186, P = 0.5929). All covariates were significantly associated with CV-rates. The model did not suffer from multicollinearity and the model goodness-of-fit was satisfactory (P = 0.5575). CONCLUSIONS: In a managed care population with type-2 diabetes after adjusting for known baseline differences, CV-risks among subjects who used statin+fibrate combination-therapy compared to those who used statin-only monotherapy did not significantly differ. This is different from what people expected for the combination-therapy, due to low power resulting from small sample size for combo-group. We hope this result will be useful in health policy to find treatment strategies to reduce CV-risk in diabetics. Future research is in progress to address the causality behind this association.

**PCV9**

**COMPARATIVE EFFECTIVENESS OF INDIVIDUAL ANGIOTENSIN-CONVERTING ENZYME INHIBITORS IN PATIENTS WITH CHRONIC HEART FAILURE**

Chitus A, Sharma M*, Tadav R*, Chen H*, Aparasu K, Johnson ML*

University of Houston, Houston, TX, USA; *College of Pharmacy, University of Houston, Houston, TX, USA

OBJECTIVES: There is limited evidence of comparative effectiveness of individual Angiotensin Converting Enzyme (ACE) inhibitors for treatment of heart failure. We compared the comparative effectiveness in patients with Chronic Heart Failure (CHF).

METHODS: The study was a retrospective analysis of a national cohort of patients diagnosed with CHF from October 1, 1996 through September 30, 2003 identified from the Department of Veterans Affairs electronic medical records system. The independent variables of interest were individual ACE inhibitors treatment, including: Benazeptil, Captopril, Enalapril, Fosinopril, Lisinopril, Quinapril, and Ramipril. Outcome measured was death within one year. Cox-proportional hazards analysis was employed to adjust the association between these treatments and mortality within one year. Multiple Cox regression controlling for demographic factors, duration of heart failure, comorbidities and comedations. RESULTS: A total of 188,845 patients with CHF were identified. Majority of the patients were males (94.74%) and whites (33.68%). Lisinopril (71.93%) was the most commonly prescribed ACE inhibitor followed by Fosinopril (20.90%) and Captopril (6.39%). In the multivariable model, Enalapril, adjusted hazard ratio was 0.715 (95% CI: 0.584 − 0.876), Fosinopril, adjusted hazard ratio was 0.778 (95% CI: 0.729−0.830), and Lisinopril 0.784 (95% 0.740−0.831) were found to have a statistically significant protective effect as compared to Captopril (referent group). Benazeptil, Ramipril, and Quinapril were not statistically significantly different from Captopril. CONCLUSIONS: Enalapril, Fosinopril and Lisinopril were associated with significantly reduced risk of death within one year further. Research is needed to examine other outcomes including cost-effectiveness of ACE inhibitor use in the treatment of heart failure.

**PCV10**

**COMPARATIVE EFFECTIVENESS OF INDIVIDUAL ANGIOTENSIN RECEPTOR BLOCKERS IN PATIENTS WITH CHF**

Dezi R*, Chen H*, Morgan R*, Johnson M*

University of Houston, Houston, TX, USA; *University of Texas, Houston, TX, USA

OBJECTIVES: There is limited evidence of comparative effectiveness of Angiotensin Receptor Blockers (ARBs) for the treatment of Chronic Heart Failure (CHF). We compared the clinical effectiveness of Losartan, Valsartan, Candesartan, Telmisartan and Irbesartan in patients with CHF. METHODS: The study was a retrospective cohort study utilizing national Veterans Affairs electronic medical records. The cohort consisted of all heart failure patients diagnosed between October 1, 1997 to September 30, 2002. After excluding patients with any exposure to ARBs within the previous 6 months, new exposure to ARBs was determined between the index date (October 1, 2000) and the study end date (September 30, 2002) and subsequent time to death was measured concurrently during that period. Five treatment groups were defined based on initial use of: Candesartan, Valsartan, Losartan, Irbesartan, and Telmisartan. Multiple Cox proportional hazards regression analysis was employed to assess the adjusted association between these treatments and time to death after controlling for demographics, hospitalization, years with CHF, 30 comorbidities and comedations. Losartan was chosen as the reference drug because it was the first ARB introduced into the market. RESULTS: Total 19,186 patients were identified. Majority of the patients were male (98.06%). The most common comorbid condition in the cohort was hypertension (81.17%) followed by Ischemic Heart Disease (68.65%) and diabetes (46%). In Losartan, (55.50%) was the most commonly prescribed ARB followed by Losartan (19.44%). In the multivariable model Losartan was found to have a statistically significant decreased risk as compared to telmisartan, adjusted hazard ratio for telmisartan was 1.68 (95% CI: 1.12 − 2.46)Irbesartan, Valsartan, and Candesartan were not statistically significantly different from Losartan. CONCLUSIONS: All of the ARBs had similar associations with time to death, except telmisartan, which had a statistically increased risk of mortality within two years. Further research is needed to examine other outcomes including cost-effectiveness in the treatment of heart failure.