C), and triglyceride (TG) goal attainment, annual cardiovascular disease (CVD)-related health care utilization and costs among patients initiating combination statin and extended-release niacin (NER) therapy (S + NER + S). METHODS: A retrospective cohort study of patients initiating S + ERM between January 1, 2000 and June 30, 2006 was conducted utilizing medical, pharmacy and laboratory result data from the HealthCore Integrated Research Database. Patients were primary or secondary risk, aged ≥18 years, had ≥1 laboratory result monthly to index date, and ≥12 months pre- and post-index eligibility. Clinical and economic outcomes were evaluated during the 12 months prior to and after initiation of S + ERM. Lipid goal attainment was determined based on US national lipid guidelines. CVD-related resource utilization and costs were annualized post-index. Change in lipid goal attainment, annual resource utilization and costs were tested using Generalized Estimating Equations (GEE). Model covariates for lipid goal attainment included age, gender, time to NER addition, and co-morbidity index. RESULTS: A total of 945 (51% secondary risk) patients initiating NER + S were identified. Patients were predominantly male (77%), mean age 52.6 ± 9.05 years and time to addition of NER was 225 ± 306 days. Mean change in lipid values (mg/dL) for LDL-C, HDL-C, and TG was: −10.81 ± 30.67, 2.73 ± 7.24 for HDL-C, and −22.67 ± 106.79 respectively. Multivariate analysis demonstrated increased likelihood of goal attainment for LDL-C (OR: 1.56; p = 0.0078) after initiation of NER + S therapy. GEE results demonstrated significant improvement from pre-index in annual CVD attributable inpatient visits (17 ± 49 vs 9 ± 31 per 100 patients; p < 0.0001) and total medical cost ($3214 ± 10,282 vs. $2039 ± 7117; p < 0.0001). CONCLUSIONS: Comprehensive treatment approach of combination NER + S therapy was associated with improved change in lipid values, target lipid value attainment, and reduced CVD-related inpatient visits and total medical cost.

PCV84

HEALTH CARE RESOURCES AND QUALITY OF LIFE IN ACUTE CORONARY SYNDROME PATIENTS IN 2007: BASELINE RESULTS FROM THE ANTIPLATELET TREATMENT OBSERVATIONAL STUDY (APTOR)

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OBJECTIVES: This analysis aims to explore management of acute coronary syndromes (ACS) from acute event to hospital discharge in France. METHODS: This 12-month prospective, observational study recruited ACS patients undergoing percutaneous coronary intervention (PCI), January-August 2007, capturing practice patterns, resource use and quality of life. In France, all interventional cardiologists were invited to participate. RESULTS: 497 ACS-PCI patients (483 analyzed), enrolled by 59 interventional cardiologists from public universities hospitals-36%, public non-university hospitals-45%, and private hospitals-19%, were: mean age 60.9 ± 12.8, mean weight 79.7 kg ± 14.8, 18% female, 16% diabetics and 12% prior myocardial infarction (MI). Index diagnosis was: unstable angina or non-ST-elevation MI (UA/NSTEMI)-53% and ST-elevation MI (STEMI)-47%. Almost all patients (96%) were implanted stents: 67% bare metal stents (BMS), 23% drug eluting stents (DES) and 11% both. Antiplatelet loading oral medications used were aspirin-91% and clopidogrel-95% (no use of ticlopidine). Antiplatelet agents were infused too: abciximab-16%, tirofiban-18%, eptifibatide-3%, and bivalirudin-3%. Clopidogrel loading dose (LD) was given in intensive care unit-32%, emergency room-24%, ambulance-21%, previous hospital-12%, catheter lab-6% and other ward-4%, and close to PCI (previous 6 hours, during or after) in 46% of cases. Total clopidogrel loading dose was over 300 mg in 34% of cases, and in-hospital maintenance dose (MD) was 150 mg in 26%, and 75 mg in 74% of cases. At time of hospital discharge, 96% of patients were receiving clopidogrel (discharge dose 150 mg in 23%) and EQ-5D QoL score was a median 0.85 (IQR 0.73–1.00). CONCLUSIONS: These data reflect contemporary real-life management of ACS patients in France. DES are implanted 3 times less than BMS. Variation in oral antiplatelet agent dosing pattern (LD and MD) and timing of administration is frequent.

PCV83

AN EVALUATION OF THE INCREMENTAL CHANGE IN THE INCIDENCE OF CARDIOVASCULAR EVENTS AND RELATED COSTS WITH THE ADDITION OF FIXED-DOSE NIACIN EXTENDED-RELEASE AND SIMVASTATIN THERAPY TO THE MANAGED CARE FORMULARY

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OBJECTIVES: To model the impact of the addition of fixed-dose niacin extended-release and simvastatin (NER/S) therapy to a health plan formulary in terms of cardiovascular (CV) events and corresponding attributable costs. METHODS: Two hypothetical formularies with all major branded and generic lipid drugs were modeled over a three year time horizon: a formulary not including NER/S (current formulary) and a formulary which did (revised formulary). Primary and secondary risk patients with ≥1 sub-optimal lipid parameter were sampled from the HealthCore Integrated Research Database between 1/1/2000 and 2/28/2005. Package insert efficacy of antihyperlipidemic medications in each formulary was applied to brand and generic wholesale acquisition costs. RESULTS: For every 1% increase in NER/S market share there was a corresponding 0.38% increase in the incremental rate of combined OLV achievement and 0.06% decrease in the incremental incidence of CV events between current and revised formularies. Total health system drug expenditure increased by 15% while CV event costs decreased by 10%. The incremental cost per CV event avoided was $46,593 and $12,957 per CV event related hospital day avoided. CONCLUSIONS: The addition of NER/S to the health plan formulary increases combined optimal lipid value achievement and correspondingly reduces the three year incidence of CV events and CV event related costs in this hypothetical patient population.
disability. METHODS: Randomly selected Athens Stroke Registry ischemic stroke patients, 18 years of age or older, still alive at least 90 days post stroke and willing to attend a study visit were administered a 30-day retrospective resource use questionnaire, the EQ-5D, the Stroke Impact Scale (SIS-16), Modified Rankin Scale (mRS), and Barthel Index; caregivers reported resource use and hours of informal care. Stroke history was obtained from registry records. RESULTS: A total of 365 subjects (65% male; mean age 71 years) were enrolled at a mean time post stroke of 2.8 years (min 0.3-max 14.2 years). At the study visit, post-stroke disability was evenly distributed (mRS: 0 = 17%; 1 = 17%; 2 = 17%; 3 = 17%; 4 = 16%; 5 = 16%); 98% (n = 357) of patients were residing at home, but 57% (n = 205) of these needed help with ADLs. Of the 2% (n = 8) who resided in a long-term care facility, all had severe disability (mRS 3,4,5). Mean informal care time received by patients with severe disability over the previous 7 days by all caregivers in the family was 145.4 (SD = 67.6) hours; patients with mild/moderate disability (mRS 0,1,2) disability received 52.6 (SD = 44.2) hours (p < 0.001). CONCLUSIONS: Despite moderate or severe disability in a substantial proportion of this Greek cohort, most of these post-stroke patients were cared for by their caregivers at home. Post-stroke impairment remains an important determinant of caregiver burden well beyond the acute care period, which can translate into significant lost productivity costs.

CARDIOVASCULAR DISORDERS—
Patient-Reported Outcomes Studies

PCV86
COMPARISON OF PERSISTENCE AND ADHERENCE BETWEEN PRASUGREL AND CLOPIDOGREL IN THE TREATMENT OF PATIENTS WITH ACUTE CORONARY SYNDROMES AND PERCUTANEOUS CORONARY INTERVENTIONS
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OBJECTIVES: In patients with acute coronary syndromes (ACS), continued treatment with thienopyridine regimens has been associated with fewer major adverse cardiac events. In the TRITON-TIMI 38 trial, prasugrel was compared to clopidogrel in ACS patients undergoing percutaneous coronary intervention (PCI) resulting in a 19% reduction in cardiovascular death, myocardial infarction, or stroke, but an increase in TIMI defined bleeding (10.9% vs 7.9%, p < 0.001). The impact of these complications on medication persistence and adherence is unknown. The objective of this study was to compare persistence and adherence of clopidogrel and prasugrel in TRITON TIMI-38.

METHODS: TRITON TIMI-38 was a double-blind, randomized, controlled trial which enrolled 13,608 patients with ACS and planned PCI. Of the 13,608 patients enrolled, 13,457 patients received at least one dose of study drug and were evaluated for this study. Patients treated with prasugrel (N = 6,741) or clopidogrel (N = 6,767) were followed for up to 15 months. Adherence was calculated using the medication possession ratio (MPR), the total days with medication divided by total days in the study. Persistence was measured as the time from randomization to the first gap of >14 days between exhausting the supplied medication and filling the next prescription. Sensitivity analyses using gaps of 7 and 30 days were performed. Clopidogrel and prasugrel adherence and persistence were compared using multivariate linear regression, controlling for demographics and illness history. Robustness of results was examined using alternative modeling. RESULTS: A total of 17.6% of patients prematurely discontinued study drug (prasugrel, 17.9% vs. clopidogrel, 17.3%, p = 0.382). The MPR for prasugrel (0.96) and clopidogrel (0.96) were similar (p = 0.801). Similar persistence levels between prasugrel-treated patients and clopidogrel-treated patients were observed using the 14-day gap (319 vs. 322 days, p = 0.296). Sensitivity analysis using 7-day and 30-day gaps confirmed these findings. Study drug was discontinued for a hemorrhagic adverse event (AE) in 2.5% of prasugrel patients compared to 1.4% of clopidogrel patients (p < 0.001) and stopped for a non-hemorrhagic AE in 4.6% vs. 5.0% (p = 0.372). CONCLUSIONS: Despite an increase in TIMI defined bleeding and an increased rate of discontinuation of study drug for a hemorrhagic event with prasugrel, similar levels of adherence and persistence were observed for prasugrel-and clopidogrel-treated ACS patients with PCI in TRITON TIMI-38. Further study will be necessary to determine whether these results can be replicated outside of the clinical trial setting.

PCV87
PERSISTENCE WITH AMIODARONE OR SOTALOL AND ITS IMPACT ON ATRIAL FIBRILLATION-RELATED HOSPITALIZATIONS AND CARDIOVERSIONS
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OBJECTIVES: This study examined persistence with amiodarone and sotalol and the effect of stopping treatment on atrial fibrillation (AF)-related hospitalizations and cardioversions.

METHODS: A cohort of patients with a diagnosis of AF recorded between 1999 and 2005 was assembled from the PHARMetrics® database. The cohort included treatment-naïve adults aged 40 years or older who established treatment with amiodarone or sotalol (at least two consecutive prescriptions). Discontinuation was defined as a gap in availability of the index treatment lasting at least 60 days, or one refill period plus one month, whichever was longer. Patients were followed until outcomes of interest or end of follow-up, defined as end of administrative data, change in coverage, switching to or adding another treatment, or restarting treatment after not persisting. The impact of persistence on hospitalizations and on cardioversions was assessed using Cox regression models with a time-dependent indicator for persistence adjusting for baseline covariates.

RESULTS: Over a mean follow-up of 1.26 years of 8193 patients (65.5% male, mean age 67 years), persistence with amiodarone was 44% after one year and 60% with sotalol (median times: 9.4 vs. 19 months, respectively; p < 0.001). By the third year, only 20% were still on amiodarone and 30% on sotalol. The majority of patients (62%) did not collect any prescription after discontinuation. Of those who did, patients taking sotalol were more likely to switch to or add another treatment, while patients on amiodarone tended to restart on the same drug. Persistence was associated with a decreased risk of cardioversions (hazard ratio, HR = 0.37, 95%CI: 0.25–0.56), but only borderline with hospitalizations (HR = 0.86, 95%CI: 0.79–1.02). CONCLUSIONS: Persistence with amiodarone or sotalol is generally poor, and patients who discontinue treatment are unlikely to restart at a later time. Stopping treatment was associated with increased risk of cardioversions and a trend of increased AF-related hospitalizations.