parametric data. OLS regression tested the relationship between duration of therapy and presence of CHD risk factors. RESULTS: For each statin, days on therapy differed significantly (p < 0.001) by the number of risk factors. The number of CHD risk factors was positively significant in predicting duration of therapy (p < 0.0001) in both new and continuing therapy. Duration of therapy was associated with an increase of 48 days for each risk factor for new patients and 58 days for continuing patients. CONCLUSIONS: Number of CHD risk factors is positively correlated with length of therapy when using statins as lipid lowering therapy for new and continuing patients.

**Table 1: Days on Therapy by Risk Factor**

<table>
<thead>
<tr>
<th>Statin</th>
<th>Risk Factors (RF)</th>
<th>RF: 0</th>
<th>RF: 1</th>
<th>RF: 2</th>
<th>RF: 3 OR 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Median</td>
<td>305</td>
<td>431</td>
<td>481</td>
<td>550</td>
<td></td>
</tr>
<tr>
<td>Atorvastatin</td>
<td>345</td>
<td>419</td>
<td>424</td>
<td>562</td>
<td></td>
</tr>
<tr>
<td>Fluvastatin</td>
<td>289</td>
<td>428</td>
<td>505</td>
<td>568</td>
<td></td>
</tr>
<tr>
<td>Pravastatin</td>
<td>303</td>
<td>444</td>
<td>469</td>
<td>533</td>
<td></td>
</tr>
</tbody>
</table>

**PCV16**

CARING FOR HYPERTENSION ON INITIATION: COSTS AND EFFECTIVENESS (CHOICE). DESIGN AND RATIONALE OF A NATURALISTIC STUDY

Payne K1, Caro J1, Hollenberg N2, Jackson J3, L’Italien G3, for the CHOICE Study Group

1Caro Research Institute, Dorval, QC, Canada; 2Harvard Medical School and Brigham and Women’s Hospital, Boston, MA, USA; 3Bristol-Myers Squibb, Princeton, NJ, USA

INTRODUCTION: Naturalistic studies are essential to prospectively study real-world antihypertensive treatment. OBJECTIVE: to evaluate the feasibility of performing a naturalistic study in newly diagnosed hypertensives in terms of enrollment, adequacy, timeliness of data collection, and study procedures. METHODS: CHOICE prospectively collected actual practice data on the treatment of newly-diagnosed hypertensive patients. Initial therapy was randomly assigned to either Group 1 (beta blockers or diuretics) or Group 2 (ACE inhibitors or calcium channel blockers). The protocol made no demands in scheduling visits or changing treatment during follow-up. Physicians were blind to study purpose and hypotheses. Only a final visit at 5 ± 1 months, if none occurred naturally, was mandated. Direct involvement of the CHOICE study team was minimized using a Remote Study Monitoring System to collect data and communicate with study sites. RESULTS: Within 30 weeks, a total of 55 physicians enrolled 512 patients with a mean age of 51 years and blood pressure of 158/99 mmHg. In all, 46 different antihypertensive medications were prescribed and 2,554 office visits (range = 1–16 visits per patient) were attended. Other medical resource use was low during the study period. A final, clean database was ready for analysis 30 days after last patient last visit. CONCLUSIONS: It has been demonstrated that CHOICE is a feasible framework to study the real-world effectiveness of initial therapy for newly diagnosed hypertension. Protocol flexibility and a novel electronic data entry system are core elements of this naturalistic design.

**PCV17**

A PHARMACOECONOMIC MODEL TO EVALUATE TREATMENT OPTIONS FOR DVT PHARMACOPROPHYLAXIS

Spruill WJ, Wade WE, Leslie RB

University of Georgia College of Pharmacy, Athens, GA, USA

Economic analysis of various treatment modalities used to prevent deep vein thrombosis (DVT) in various medical and surgical at-risk patients has been limited by lack of consistent and representative methods to evaluate various resource costs attributed to both the prevention of DVT and the diagnosis and treatment of prophylaxis failures. OBJECTIVE: To develop a systematic and comprehensive method to identify and prioritize all direct costs associated with DVT prophylaxis. METHODS: A decision tree was developed to identify and prioritize all medical, surgical and diagnostic procedures that contribute to overall direct cost. Included were costs of prophylaxis, cost of diagnosing a prophylaxis failure (a DVT) and costs of major complications of this therapy (pulmonary embolism, major bleeding and thrombocytopenia.) Diagnostic procedures were also prioritized clinically as either a “standard”, “alternative or confirmatory”, or “supplemental” procedure. This prioritization allows for probability multipliers to be assigned to each category of diagnostic procedures in order to get a weighted average of the cost of this procedure. Likewise, the various costs associated with prophylaxis failure were prioritized. Next a spreadsheet was developed to match this decision tree. This spreadsheet contained all identified resource costs shown on the decision tree and indicated the quantity or units of each resource that are typically used. Lastly, the corresponding CPT and ICD9 codes for all resources were identified. RESULTS: Major categories of resources identified include diagnostic, treatment, and monitoring. These 3 areas are divided into 13 sub-categories which in turn include over 60 specifically identified cost related resources. CONCLUSION: This model allows any institution to accurately identify, prioritize and analyze institution specific resource costs instead of using literature values to determine the cost-benefit of various pharmacoprophylactic regimens including unfractionated heparin and various low molecular weight heparins used at their site.

**PCV18**

CHOLESTEROL REDUCTION SUCCESS RATES AND RESOURCE UTILIZATION BY GENDER

Graff JS1,2, Plante M1, Smith D2

1Pfizer Inc, Ann Arbor, MI, USA; 2University of Michigan, Ann Arbor, MI, USA

Abstracts