OBJECTIVES: To identify what was the influence of cardiovascular drugs recommended by AOTM in years 2005-2012 for the reimbursement list officially published by MoH (January 2013).

METHODS: First, among total 1,226 items, 360 combination items were excluded from this evaluation and 25 essential items (ban-on-delisting drugs, orphan drugs, emergency drugs, and drugs with any alternatives) were to remain for the reimbursement list without any evaluation. Next, clinical usefulness was evaluated by criteria from medical textbooks, guidelines, and WHO lists, and 1,3 items and was to be delisted due to lack of clinical usefulness. In the third step, daily cost was calculated. Drugs which belong to bottom 25% in daily cost were defined as "relatively low-price drugs," which could remain on the list without subsequent evaluation. Other drugs were to be evaluated by cost-effectiveness. Clinical effectiveness was evaluated based on proxy outcomes (blood pressure) and final outcomes (mortality, morbidity) by reviewing clinical literatures and 6 assessment reports from overseas health technology institutions as well as opinions of clinical experts.

RESULTS: There was no clear evidence depicting differences in clinical effectiveness among the classes. On the other hand, the prices of higher-priced drugs would have to decrease down to the lowest level of all hypertension drugs if a cost-minimization principle is applied. However, the lowest levels within each class were suggested instead in recognition of differences in adverse events and effects on co-morbidity among the classes. CONCLUSIONS: It was not possible to identify a particular combination or ingredient among hypertension drugs was superior to others. However, the policy based on this result has to be carefully implemented. It is important that practicability, fairness, and integrity of the result as well as scientific accuracy have to be balanced since this type of study is considered to be associated with interests of stakeholders.

OBJECTIVES: To examine the demographic and clinical characteristics, and cardiovascular treatment in patients with high-risk vascular disease (HRVD).

METHODS: To conduct this retrospective cohort study. Patients with HRVD (defined as cerebrovascular disease (CVD), coronary artery disease with diabetes (CADD), peripheral artery disease (PAD), or history of acute coronary syndrome [ACS] >30days through 365 days after discharge for ACS)) between October 1, 2008 to September 30, 2009, ≥65 years of age, were identified with minimum 12-month pre- and 24-month post-index health plan eligibility. Patients’ baseline demographic characteristics, comorbidities, and medication use were compared and across groups with and without polypolyvascular disease. RESULTS: There were 555,893 HRVD patients identified with an average age of 77.2 years and gender of 51.0% male. Of the identified patients, 59.5% had hypertension, 32.9% had hypercholesterolemia, and 44.7% had diabetes. Patients were associated with statins (50.3% HRVD vs 54.0% CADD), antiplatlets (21.4% HRVD; range: 16.8% CVD to 49.7% ACS), beta-blockers (41.8% HRVD; range: 35.2% CVD to 67.1% ACS), and other evidence-based risk reduction therapies. Patients with ≥1 affected artery bed (18%) had numerically similar age (77.1±7.6, 77.0±4.3 affected disease beds), but had higher cardiovascular risk factors (for 1, 2, 3 affected disease beds, hypertension: 57.2%, 69.1%, 73.4%, hypercholesterolemia: 32.0%, 36.6%, 37.3%, diabetes: 45.3%, 51.2%, 53.6%, and used more cardiovascular-related medications (for 1, 2, 3 affected disease beds, antiplatlets: 48.0%, 59.9%, 67.5%, atorvastatin: 18.3%, 33.8%, 48.8%, beta-blockers: 39.0%, 53.3%, 64.4%) compared to patients with only 1 affected artery disease bed (p<0.01). The average number of medications per patient was 9.1 for HRVD patients and 6.6 for the patients for ACS, CADD, CVD, and PAD (N=1456). CONCLUSIONS: In elderly HRVD patients, cardiovascular risk factors are consistent and common, but are undertreated in the U.S.
ACS patients with AF. **METHODS:** Olmsted County, Minnesota residents hospitalized with incident myocardial infarction or unstable angina during 2005-2010 were identified and classified according to the presence or absence of AF either prior to or during the index ACS hospitalization. Logistic regression identified factors associated with double/triple versus none/single antithrombotic therapy in those with AF. **RESULTS:** Of 1108 incident ACS atients, 229 (20.7%) had concomitant AF (ACS+AF). Only 15.7% ACS+AF patients underwent percutaneous interventions (PCI) in contrast to 35.4% ACS patients without AF having PCI. AF substantially impacted the choice of antithrombotic strategy at discharge. Nearly half (49.3%) of the ACS+AF patients were discharged on either two or three antithrombotic agents; 39.3% received aspirin only. One-third (33.6%) of those with ACS+AF received warfarin, mostly in combination with a single antiplatelet, and 10.0% of patients received warfarin with two antiplatelet agents. In contrast, among ACS patients without AF, 63.5% were discharged on either two or three agents, the majority on dual antiplatelets, with only 3.8% on warfarin and 1.3% on warfarin with two antiplatelets. After adjustment for age and sex, the predictors of double/triple agent treatment strategies in ACS+AF patients included higher peak troponin, PCI on index admission, higher body mass index, non-smoking status, hypertension, and higher CHADS2 score. **CONCLUSIONS:** In the community, AF frequently coexists with ACS. AF, in conjunction with patient-level risk factors, influences the choice of antithrombotic agents in ACS patients. These observational data underscore the importance of ACS+AF and the need for evidence from randomized trials and observational studies to guide clinical decisions.