medication upon discontinuing clopidogrel. CONCLUSION: Clopidogrel was the dominant oral antiplatelet by market share. These patients also used significant pharmacy resources on other medications. While average duration was largely consistent with treatment guidelines, variations in individual treatment length were detected. This finding suggests inconsistencies in utilization versus treatment guidelines. Early discontinuation of cardiac medications in some patients also raises concern.

PCV34
COST OF CONSUMABLES ASSOCIATED WITH CARDIOVASCULAR COMPUTED TOMOGRAPHY ANGIOGRAPHY: THE CARDIOLOGIST’S PERSPECTIVE Vishalpura T1, Callister TQ2, Sarnes MV3 1Xcenda, Yarndle, PA, USA, 2Tennessee Heart and Vascular Institute, PC, Hendersonville, TN, USA, 3Xcenda, Palm Harbor, FL, USA
OBJECTIVES: Computed tomography angiography (CTA) scanners have advanced patient care by providing cardiologists with the latest in imaging technology. When deciding to purchase a CTA scanner, practices must evaluate the economic feasibility of ownership in terms of both fixed (eg, equipment and facility costs) and variable costs (ie, consumables costs). The objective of this study was to provide cardiology practices with a comprehensive cost estimate for the cost of consumables incurred for CTA procedure. METHODS: Practice patterns from a large cardiology practice were evaluated for all CTA procedures over an eight-month timeframe. The various consumables utilized for CTA procedures were captured and classified into three main categories: contrast media, drugs, and medical supplies. The average utilization of each consumable was then evaluated, and the unit acquisition cost for each consumable was applied to quantify the average cost of consumables per CTA procedure. RESULTS: From January 2006 through August 2006, data from 3119 procedures were evaluated. The average cost of consumables per procedure incurred by the practice was $83.31. Of this cost, $32.55 was incurred for contrast medium. Additionally, $9.91 was the average cost per procedure incurred for drugs such as beta blockers, solu-medrol, diphenhydramine, intravenous fluids, nitrolingual spray, and antiemetics. The largest component of consumables was medical supplies (eg, syringes, needles, tubing, cannulae, intravenous catheter, dressing/bandages, table paper, gloves, alcohol pads, etc), which cost the institution an average of $40.85 per procedure. CONCLUSION: When evaluating the economic feasibility of operating a CTA scanner, cardiology practices can expect to incur an average of $83.31 per procedure for consumables.

PCV35
IMPACT OF NESIRITIDE ON TREATMENT OF ACUTE DECOMPENSATED HEART FAILURE (ADHF): EVIDENCE FROM A US HOSPITAL DATABASE DiDomenico R1, Sengupta N2, Barker C2 1University of Illinois at Chicago, Chicago, IL, USA, 2Scios Inc, Mountain View, CA, USA
OBJECTIVES: Compare impact of nesiritide (a recombinant natriuretic peptide approved for intravenous treatment of ADHF) administration within first day versus after first day on in-hospital outcomes using an inpatient claims database of 400+ US hospitals and 600,000+ discharges (PREMIER). METHODS: From 681,690 discharges during 2003 and 2004 in the PREMIER database, we studied patients with DRG 127 at discharge and ICD 9 codes for primary diagnosis of CHF. First day nesiritide (D1) was defined as nesiritide + diuretic administration within 1st day of hospital admission; post-first-day administration (post-D1) was defined as nesiritide administration after first hospital day with diuretic therapy during first day. Four outcomes variables were analyzed: discharge status, hospital and ICU LOS, and hospitalization cost. Propensity matching and propensity covariate adjustments were performed in all regression analyses to remove bias in between-group comparisons. RESULTS: In all, 8126 patient discharge episodes were identified as D1 and 793 as post-D1. The D1 group had reduced mortality odds versus post-D1 (0.46, 95% CI: 0.36, 0.59, P < 0.0001). Hospital and ICU LOS were shorter for D1 versus post-D1 (~4.5 days [95% CI: −4.9, −4.2, P < 0.0001] and −1.7 days [95% CI: −2.5, −1.5, P < 0.0001], respectively). Hospital costs were lower for D1 patients (D1-Post D1): $−6642 (95% CI: $−7226, −$6058, P < 0.0001). Adjusted and unadjusted analyses on all four outcomes were consistent and achieved statistical significance. CONCLUSION: This analysis demonstrated that in two groups of propensity-matched hospitalized patients, those treated with nesiritide within the first day of hospital admission have better outcomes than those treated with nesiritide later. These findings are based on retrospective data sources. A recently announced prospective randomized, controlled global clinical trial enrolling 7000+ patients (ASCEND-HF) will provide additional information.

PCV36
THE EFFECT OF DRUG COST-SHARING ON ADHERENCE TO CHRONIC MEDICATIONS Patrick A1, Maclure M1, Dormuth C2, Glynn RJ3, Schneeweiss S4 1Brigham and Women’s Hospital, Boston, MA, USA, 2University of Victoria, Victoria, BC, Canada, 3University of British Columbia, Vancouver, BC, Canada, 4Harvard Medical School / Brigham and Women’s Hospital, Boston, MA, USA
OBJECTIVES: To study the effects of two sequential changes in drug cost-sharing policies on adherence to statins and beta-blockers by seniors in British Columbia. METHODS: For each drug class, we identified a baseline cohort of subjects initiating therapy in the 6 months prior to January 1, 2001, a co-payment cohort initiating therapy in the 6 months prior to the co-payment policy introduced January 1, 2002, and a co-insurance cohort initiating therapy in the 6 months prior the co-insurance policy introduced May 1, 2003. We calculated the proportion of patients adherent in each cohort each month, with follow-up for each cohort beginning at the start of that cohort’s recruitment period and ending 15 months later. Patients were defined as adherent during a month if they had a proportion of days covered (PDC) of 80% or greater, calculated by dividing the number of days the patient had drug supply available by the number of cohort membership days the patient contributed in that calendar month. RESULTS: In the baseline cohort, which did not experience cost-sharing, 53.8% of statin initiators were adherent to their statins at month 15. The adherence level in the co-payment cohort at this time, 9 months after the introduction of the co-payment policy, was 50.5%. 50.8% of co-insurance cohort member were adherent. Adherence to beta-blockers was lower, with 48% of the baseline cohort initiators adherent at month 15. However, the introduction of the co-payment and co-insurance policies reduced this adherence level by only 1 percentage point. CONCLUSION: The introduction of the co-payment and co-insurance policies reduced adherence to statins by 5 percentage points relative to baseline levels, but had a much smaller effect on beta blocker adherence levels. Policy-
matters should consider drug cost as a potential modifier of policy effects.

THE IMPACT OF CARE GAP IN MANAGING HIGH CARDIOVASCULAR RISK PATIENTS: A CANADIAN POPULATION ANALYSIS

Grima DT, Langer A, Leiter L, Attard C, Chow CM, Goodman S
1Cornerstone Research Group Inc, Burlington, ON, Canada, 2Canadian Heart Research Centre, Toronto, ON, Canada, 3University of Toronto, Toronto, ON, Canada

OBJECTIVES: Each year 500,000 Canadians are hospitalized and 79,000 die due to cardiovascular disease (CVD). Strong evidence supports the use of “triple” therapy with ASA, statin, and angiotension converting enzyme inhibitors (ACEi) in patients with CVD or diabetes; however current care only partially reflects this evidence. The objective was to quantify the reduction in CV events (MI, stroke, CHD/stroke/death) with triple therapy compared to current care in high-risk patients over the age of 50. METHODS: Patients at high risk (either diabetes, prior myocardial infarct and/or stroke) were included. Canadian Community Health Survey (CCHS) data for 2003 were used to estimate prevalence of disease, which was applied to the age-specific population in Canada in order to calculate the total number of high risk patients. Event risk was calculated based on the Framingham risk equations. Current use of triple therapy was derived from a Canadian registry of high risk patients (n = 5,095). Values for risk factors were based on the CCHS and the registry. A relative risk reduction of 54% for all events was assumed for triple therapy compared to no treatment, based on trial data. RESULTS: Current usual care has reduced the number of cardiovascular events from an estimated 1.01 M to just over 600,000 over the next 10 years. However, of the 2.2 million high risk patients, approximately 64% of them do not receive triple combination therapy. It is estimated that an additional 143,041 cardiovascular events, including 37,703 cardiovascular deaths, could be prevented over the next ten years by treating all high risk Canadians over the age of 50 with triple combination therapy. CONCLUSION: Canadian physicians have done well in reducing the burden of CVD. More optimal guidelines based management of high risk patients can significantly reduce CVD mortality and morbidity and must be strongly encouraged.

TREATMENT OF DEPRESSION IN CORONARY ARTERY DISEASE: A STUDY OF NATIONAL AMBULATORY MEDICAL CARE VISITS FROM 2000 TO 2004

Sankaranaryanan J, Dobesh P
University of Nebraska Medical Center, Omaha, NE, USA

OBJECTIVES: Little is known about treatment of depression in coronary artery disease (CAD) at ambulatory visits in United States. METHODS: Retrospective analyses were conducted of the combined 3-year data (2000–2004) of physician office-based National Ambulatory Medical Care Survey (NAMCS) and outpatient and emergency department based National Hospital Ambulatory Medical Care Survey (NHAMCS). Visits with coronary artery disease (ICD-9-CM 410–414) and depression disorder (296, 311) were identified. The visits combined across the three settings were classified into CAD visits with and without depression. Sample estimates were weighted and projected to the population with 95% confidence intervals. Multivariate logistic regression was used to determine significant characteristics of antidepressant treatment mention at visits. RESULTS: About 1.23 million ambulatory visits or 0.79% (95% CI: 0.51–1.21) of all adult CAD associated visits also had a diagnosis of depression. Antidepressant medication (TCA, MAOI, SSRI, or bupropion) was associated with 7.75% (95% CI: 6.49–9.24) of all CAD associated visits with SSRI being associated with about 5.46% of visits. In multivariate logistic-regression analysis, male gender (adjusted odds-ratio, OR, 0.47, 95%CI: 0.33–0.68), race other than Caucasian (OR, 0.38, 95%CI: 0.21–0.69), emergency department (ED) setting (OR, 0.32, 95%CI: 0.21–0.50), decreased the likelihood while recent years (2002–04) (OR, 1.42, 95%CI: 1.03–1.96), depression (OR, 7.92, 95%CI: 1.56–40.42), and any mental health disorder (OR, 4.60, 95%CI: 1.74–12.14), and number of medications (OR, 6.27, 95%CI: 3.93–9.99) significantly increased the likelihood of an antidepressant medication at CAD associated visits. CONCLUSION: About 1% and 7.75% of CAD visits were associated with depression, and included antidepressants, respectively. Further research is needed on the less likelihood of antidepressant treatment at visits by male and other ethnic minority patients, and in the ED setting with a diagnosis of CAD.

TRENDS IN THE OFF-LABEL PRESCRIBING OF 3-HYDROXY-3-METHYLGLUTARYL COENZYME A (HMG-COA) REDUCTASE INHIBITORS IN THE UNITED STATES: 1998 TO 2004

Bodhani A, Karve S, Martin BC
University of Arkansas for Medical Sciences, Little Rock, AR, USA

OBJECTIVES: To determine the trend for off-label prescribing of statins from 1998 to 2004 and to explore the different conditions in which statins are being prescribed off-label. We also sought to determine the proportion of off-label use for experimental conditions (Alzheimer’s disease, Multiple Sclerosis, Rheumatoid Arthritis, selected Cancers). METHODS: This study analyzed the National Ambulatory Medical Care Survey (NAMCS) and the National Hospital Ambulatory Medical Care Survey (NHAMCS) from 1998 through 2004. The NAMCS and NHAMCS are nation-wide surveys of non-federal physicians, hospital out-patient, and emergency departments. Statin visits were identified using generic drug codes for all marketed statins in the U.S. On-label visit use was defined as a visit that had a: primary or secondary ICD-9-CM code or reason for visit code for dyslipidemias, Acute Myocardial Infarction, Ischemic Heart Disease, Angina, Atherosclerosis, or a lipid lab test, or a CPT-4 code for a revascularization procedure. Sampling weights were used to provide national estimates. RESULTS: In 1998, there were a total of 24.8 million (95% CI: 20,883,228–28,784,766) ambulatory visits resulting in a statin prescription of which 37% were off-label. In 2004 there were 61.2 million (95% CI: 52,782,456–69,673,240) statin visits and 47% were off-label. The most common diagnoses associated with off-label visit in 2004 were hypertension (26%) and diabetes (20%). A total of 2.6% of off-label visit statin visits had a diagnosis of osteoporosis, and 1.7%, 0.5%, 0.09%, and 0.04% had cancer, Alzheimer’s disease, multiple sclerosis, and rheumatoid arthritis respectively. CONCLUSION: The prescribing of statins has grown dramatically over the past seven years and the proportion of uses without a supporting diagnosis has grown modestly from 37% to 47%. Most of the off-label visits 1998 through 2004 are for persons diagnosed with hypertension and diabetes. Use of statins for experimental purposes appears to be negligible.

UTILIZATION AND COMPLIANCE OF CALCIUM CHANNEL BLOCKERS IN THE TREATMENT OF HYPERTENSION IN THE LOUISIANA MEDICAID PROGRAM

Valderrama A, Blake S, Sherman J
The University of Louisiana at Monroe, Monroe, LA, USA