both groups, but IG patients showed an earlier control (61.8% control in IG vs 36.4% in CG at 12 weeks; p = 0.038). 1) INFONET Program: The first 250 SMS were analysed. Percentages of SMS sent by physicians were: supportive (50.3%), Therapeutic compliance (2.7%), Asking for data (29.5%), Scheduling visits to surgery (6.0%), Modifying medication (1.6%), Others (9.9%). The most frequent scheduling was one SMS every 12 days. CONCLUSIONS: In the usual practice (INFONET Program), physicians use the SMS system in a different way than predicted (HTA-Alert). They tend to give support and to ask for data, instead of addressing compliance and life-habits messages. Frequency of messages was also lower. The use of SMS seems to be a useful tool for educational programs, and it would be convenient to explore in more detail its effectiveness in health outcomes.

**PEV10**

**IMPROVED COMPLIANCE AND PERSISTENCE WITH ATORVASTATINE THROUGH A PHARMACY-BASED INTERVENTION**

de Klerk E

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OBJECTIVES: To establish the effect of a pharmaceutical care program on compliance and persistence with once-daily atorvastatine treatment in patients with elevated cholesterol levels. METHODS: An open-label, prospective controlled trial of 1-year duration was conducted in Belgium, stratified by language region. A French speaking and a Flemish speaking region were randomized to a Measurement Guided Medication Management (MGMM) intervention consisting of review by the patients’ pharmacist of the electronically compiled dosing history, a “beep-card” that reminds patient of the dosing time and educational reminders. The control group received care as usual, also stratified between the 2 regions. Compliance was measured in all patients using the Medication Event Monitoring System (MEMS®, AARDX, Switzerland), defined as the % doses taken as prescribed (once-daily). Nonpersistence was defined as the % of patients who stopped using atorvastatine before the end of the study. Because of the skewed nature of compliance data, statistical reporting includes medians, 25–75% interquartile ranges, and non-parametric tests. RESULTS: A total of 393 patients were included: intervention group: n = 194, control group: n = 199. After 1-year follow-up and stratification by region, the median % of doses taken as prescribed (25% quartile–75% quartile) was 96.1 (92.7–98.2) in the intervention group versus 89.9 (77.1–95.6) in the control group (p < 0.0001). Other compliance variables showed similar results % prescribed doses taken: 98.9 (96.3–100.3) vs 95.2 (83.0–98.9), p < 0.001, % doses within prescribed interval ±25%: 92.8 (83.9–95.9) vs 84.4 (63.0–92.5), p < 0.001 and Therapeutic Coverage: 96.1 (92.9–97.8) vs 93.6 (84.6–96.6), p < 0.001. Persistence was significantly better in the intervention group: 87.1% vs 76.9% in the control group (p = 0.02). Explanatory analysis showed that the Flemish patient group and an elevated cardiovascular risk score were significantly related to better compliance and persistence. CONCLUSIONS: Measurement Guided Medication Management improved patient compliance and persistence with atorvastatine.

**PEV11**

**PREDICTIVE VALUE OF TROPONIN T LEVELS FOR HEART FAILURE AFTER UNSTABLE ANGINA OR NON-ST-SEGMENT ELEVATION MYOCARDIAL INFARCTION**


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OBJECTIVE: Troponin T levels (TnT) predict hard ischemic events and prognosis in patients (p) with unstable angina (UA) or non-ST-segment elevation myocardial infarction (NSTEMI). There are no reports on their ability to predict the development of heart failure (HF) in that population. METHODS: In order to determine the ability of TnT to predict the incidence of NYHA class III or IV HF along three months after an episode of unstable UA or NSTEMI, TnT levels were measured to 352 p between the fifth and 24th hour from hospital admission due to an acute episode attributable to such diagnosis, being 231 men and 121 women, mean age 67.6 years (range 20 to 88). Personal or phone interview of patients or relatives were obtained three months after the acute episode looking for signs or symptoms of advanced HF. RESULTS: TnT levels were higher than or equal to 0.1 ng/ml in 135 p (TnT+ group) and less than 0.1 ng/ml in the other 217 p (TnT– group). Both groups were comparable in age (69 vs 66) and slightly different in proportion of women (42% vs 32%). Three patients died after episodes of class IV HF and all three pertained to the TnT+ group. Odds ratios (OR) and their 95% confidence intervals (CI) for the development of class III or IV HF are reflected in the table. CONCLUSIONS: Patients admitted with the diagnosis of unstable angina or non-ST-segment elevation myocardial infarction have much more episodes of advanced heart failure in the following three months when Troponin T levels are elevated in the first 24 hours of the acute ischemic episode. TnT+ TnT– n(%) n(%) OR 95%CI n NYHA III/IV 11(8.9) 5(2.4) 3.85 1.3–11.3 < 0.03 NYHA IV 7(5.5) 2(0.9) 5.88 1.2–28.7 < 0.05.

**PEV12**

**EFFECT OF EPROSARTAN ON PULSE PRESSURE PREDICTIVE FACTORS OF RESPONSE**

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OBJECTIVE: To establish the effect of once-daily atorvastatine treatment in patients with elevated cholesterol levels. METHODS: An open-label, prospective controlled trial of 1-year duration was conducted in Belgium, stratified by language region. A French speaking and a Flemish speaking region were randomized to a Measurement Guided Medication Management (MGMM) intervention consisting of review by the patients’ pharmacist of the electronically compiled dosing history, a “beep-card” that reminds patient of the dosing time and educational reminders. The control group received care as usual, also stratified between the 2 regions. Compliance was measured in all patients using the Medication Event Monitoring System (MEMS®, AARDX, Switzerland), defined as the % doses taken as prescribed (once-daily). Nonpersistence was defined as the % of patients who stopped using atorvastatine before the end of the study. Because of the skewed nature of compliance data, statistical reporting includes medians, 25–75% interquartile ranges, and non-parametric tests. RESULTS: A total of 393 patients were included: intervention group: n = 194, control group: n = 199. After 1-year follow-up and stratification by region, the median % of doses taken as prescribed (25% quartile–75% quartile) was 96.1 (92.7–98.2) in the intervention group versus 89.9 (77.1–95.6) in the control group (p < 0.0001). Other compliance variables showed similar results % prescribed doses taken: 98.9 (96.3–100.3) vs 95.2 (83.0–98.9), p < 0.001, % doses within prescribed interval ±25%: 92.8 (83.9–95.9) vs 84.4 (63.0–92.5), p < 0.001 and Therapeutic Coverage: 96.1 (92.9–97.8) vs 93.6 (84.6–96.6), p < 0.001. Persistence was significantly better in the intervention group: 87.1% vs 76.9% in the control group (p = 0.02). Explanatory analysis showed that the Flemish patient group and an elevated cardiovascular risk score were significantly related to better compliance and persistence. CONCLUSIONS: Measurement Guided Medication Management improved patient compliance and persistence with atorvastatine.