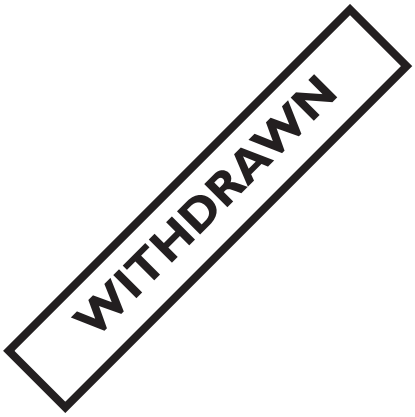
simvastatin (35.4%), atorvastatin (27.6%) and pravastatin (13.2%) were the most prescribed initial drugs. A total of 503,023 patients were considered for the adherence analysis: 34.9% of subjects had MPR < 0.4; 34.7% between 0.4 and 0.8; and 30.4% > 0.8. **CONCLUSION:** Persistent and adherence with hypolipemic medications is far from optimal in this large cohort of subjects. This phenomenon is common to many asymptomatic chronic therapies and deserves further investigations, as it indicates that a relevant part of drug resources are spent without a predictable clinical benefit.

PCV81



PCV82

FACTORS INFLUENCING COMPLIANCE WITH COMBINATION ANTIHYPERTENSIVE PHARMACOTHERAPY IN A LARGE US DATABASE

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OBJECTIVES: Combination pharmacotherapy is often necessary to treat hypertension, but can negatively impact patient compliance. This analysis assesses the impact of combination therapy with valsartan and amlodipine, with or without hydrochlorthiazide (HCTZ), on medication possession ratios (MPR) in a previously antihypertensive naïve population. **METHODS:** A national database of insured hypertensive patients > age 18 previously antihypertensive naïve was evaluated for combination pharmacotherapy. Dual therapy with valsartan and amlodipine was initiated within the first 180 days of pharmacotherapy. Triple therapy with valsartan-amlodipine-HCTZ could occur in two manners during the first 365 days of pharmacotherapy: combination as three free drug components, or a proprietary fixed dose combination of valsartan and HCTZ with amlodipine. All three groups had at least two claims for the combination during the 365 days following initiation of the combination. **RESULTS:** Using hypertension ICD-9 codes (401.0, 401.1, 401.9, 402.1 & 402.9) 908 subjects met study criteria for combination pharmacotherapy: 224 on dual therapy, 63 on free triple therapy, and 615 on fixed dose triple therapy. MPR values decreased with the increase in tablets per regimen: dual therapy 0.779, fixed dose triple 0.734, free triple 0.694 (P = 0.0149). A trend towards improved MPR with increasing age was noted between cohorts, and in the general population increased from 0.7 in ages 18–35 to 0.77 for subjects > 65 (P = 0.0058) A trend towards improved MPR with increasing severity of cardiovascular disease was also noted. MPR values for subjects with the highest disease burden (>2 comorbid cardiovascular diseases) followed a similar pattern: dual 0.791, triple fixed 0.745, triple free 0.654 (P = 0.067). **CONCLUSION:** Patient compliance improves with simplified pharmacotherapy approaches. Dual therapy provided the best MPR values, followed by triple drug therapy using two tablets (fixed dose valsartan HCTZ plus amlodipine). Other factors positively influencing compliance were advancing age and overall cardiac disease burden.

PCV83

ADHERENCE WITH ANTIHYPERTENSIVE DRUG TREATMENT: EVIDENCE FROM PRIMARY CARE PRACTICE IN ITALY

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OBJECTIVES: The study evaluates adherence with antihypertensive drug treatments in newly treated patients, outlines characteristics of patients discontinuing treatment (discontinuation risk profiling), and calculates amount of resources allocated on not effective treatment patterns (eg, discontinuation). An administrative database kept by the Local Health Unit of Pavia listing patient baseline characteristics, drug prescriptions and hospital admissions was used to perform a population-based retrospective analysis. **METHODS:** The study included all newly treated users of antihypertensive drugs, ≥18 years of age, receiving a first prescription for diuretics, beta-blockers, calcium channel-blockers, ACE inhibitors, angiotensin II antagonists or other antihypertensive drugs between January 1st, 2001 and December 31st, 2003. Patients were observed for 365 days. Adherent patients were defined as having a duration of therapy >273 days and DDD-standardized mean daily dose ≥0.8. **RESULTS:** A total of 42,000 patients were included in the study.Excluding ACE inhibitors (34.3%) other antihipertensive classes were included in a range from 13.3% up to 18.8%. The 75.1% of patients was not adherent to antihypertensive treatment. Those prescribed with angiotensin II antagonists were more likely to adhere treatment than those started on other antihypertensive classes. Poor adherence was associated with younger age, lower prevalence of concurrent chronic pharmacotherapies and lower prevalence of previous hospitalizations for cardiovascular diseases. The overall cost amounted to € 5.320 mio € of which 36.4% was accounted for not adherent patients. **CONCLUSION:** The clinical, social, and economic importance of treating hypertension requires the analysis and the implementation of tools for monitoring antihypertensive drug utilization as to assess the extent to which results from clinical research are brought into clinical practice. Administrative databases offer a powerful and low cost tool, providing detailed and useful, population-wide epidemiological and economic information for antihypertensive drug utilization.