plasma glucose (FPG) were obtained. The definition of metabolic syndrome encompasses three or more of the following abnormalities: WHR >0.9 in men and >0.85 in women, BMI ≥23.5 kg/m², BP >140/90 mmHg, FPG >110 mg/dL, HDL <40 mg/dL in men and <50 mg/dL in women, FTG >150 mg/dL.

RESULTS: Data were available in 686 Korean American subjects, 62% females. The prevalence of metabolic syndrome in our sample was 25%. Frequency of elevated BP, elevated TG, low HDL, and FPG were 32%, 21%, 29%, and 12%, respectively. Overall obesity, measured by BMI, was 35% and centrally obesity, measured by WHR, was 35%. When compared between men and women, the prevalence of metabolic syndrome in men was 32% and 20% seen among the women (95% CI, 0.061, 0.198; p < 0.001); increased central adiposity was similar in both men (35%) and women (35%); and FPG was significantly elevated in men (18%) than in women 9% (95% CI, 0.035, 0.142; p = 0.001). CONCLUSION: Multiple metabolic disorders are present in the Korean Americans. Early detection and treatment of hypertension, dyslipidemia, obesity, and glucose intolerance can prevent the progression of diabetes mellitus and CVD.

**PCV56**

EVALUATION AND COMPARISON OF DIFFERENT MODELS OF METABOLIC SYNDROME USING CONFIRMATORY FACTOR ANALYSIS

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OBJECTIVES: 1) To examine the differences in models of metabolic syndrome developed using exploratory factor analysis (EFA) versus confirmatory factor analysis (CFA) in the Insulin Resistance Atherosclerosis Study (IRAS) population; and 2) To measure validity and reliability of the variables used to measure each factor. METHODS: The subjects were from a previously studied cohort of 1087 nondiabetic participants in the IRAS, a study of the relationships among insulin resistance and cardiovascular disease risk factors. Data from this study were used to test two hypothesized models. In the first model, previously developed using EFA, two latent factors were proposed: a “hypertension factor” and a “metabolic factor,” consisting of variables measuring obesity, hyperlipidemia, and obesity status. The second hypothesized model consisted of four-factors (hypertension, hyperlipidemia, insulin resistance, and obesity). A CFA was performed testing the hypothesized models using EQS Multivariate Software Version 5.7b with maximum likelihood estimation. Construct validity and reliability of the variables used to measure the factors were then assessed in the model with best fit.

RESULTS: The 4-factor model exhibited better fit than the 2-factor model using criteria established by Hu and Bentler (chi-square = 377.3, df = 5). The final four-factor model exhibited a good fit (CFI = 0.963, SRMR = 0.036, RMSEA = 0.077). There were significant intercorrelations between all the hypothesized factors. A residual variance correlation was required between the insulin sensitivity index variable and the fasting glucose variable. All factors except the lipid factor (measured using HDL and triglycerides) exhibited good values for construct reliability and variance extracted. CONCLUSION: The results of this analyses show that metabolic syndrome is best explained by a four-factor model in the IRAS population, rather than the previously described two-factor model that was developed using EFA. The hyperlipidemia factor is not well defined, and suggests that additional variables may be required to adequately measure this factor.

**PCV57**

COST OF MAJOR BLEEDING FOLLOWING MAJOR ORTHOPEDIC SURGERY

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OBJECTIVES: While effective in reducing the risk of venous thromboembolism (VTE) following major orthopedic surgery (MOS), antithrombetics can increase the risk of major bleeding. We assessed impact of major bleeding following MOS on length of stay (LOS) and inpatient charges. METHODS: Using a database containing information on ~750,000 admissions annually to 100+ US acute-care hospitals (MQProfile, Cardinal Information Corp.), we identified all patients whom underwent MOS between January 1, 1998 and December 13, 2000. Patients were stratified according to whether or not they experienced major postoperative bleeding prior to hospital discharge, defined as: a) fatal bleeding; b) nonfatal bleeding at critical site; c) re-operation due to bleeding; and d) overt bleeding with bleeding index (BI) > 2, where BI = number of blood units transfused plus pre-bleeding minus post-bleeding hemoglobin (g/dL) values. LOS and inpatient charges were compared between patients with and without major bleeding; findings were also examined for each of the constituent measures of the composite endpoint. RESULTS: A total of 23,518 patients were identified who underwent MOS; 2.6% experienced major bleeding (fatal bleeding, 0.1%; non-fatal bleeding at a critical site, 0.2%; re-operation due to bleeding, 0.7%; and overt bleeding associated with a BI > 2, 1.7%). In multivariate analyses controlling for differences in baseline characteristics between patients with and without major bleeds, adjusted mean LOS was 1.8 days longer (95% CI: 1.5, 2.0) among the former (6.1 days vs. 4.3 days for those without bleeds); adjusted mean inpatient charges were $7593 higher (95% CI: $6622, $8646) ($25,669 vs. $18,076). CONCLUSION: Major bleeding following MOS significantly increases LOS and hospital charges. Small absolute increases in the risk of major bleeding may translate into additional costs of inpatient care that counterbalance cost savings associated with VTE events averted. Cost of major bleeding following MOS should factor into choice of VTE prophylaxis.

**PCV58**

CLINICAL AND ECONOMIC ISSUES IN THE PREVENTION OF VENOUS THROMBOEMBOLISM IN HOSPITALIZED ORTHOPEDIC PATIENTS: ENOXAPARIN VERSUS WARFARIN

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OBJECTIVES: Current American College of Chest Physicians’ guidelines recommend Venous Thromboembolism (VTE) prophylaxis for orthopedic patients. This study examines prophylactic therapy received by hospitalized orthopedic patients, rate of secondary diagnosis of VTE, and compares overall hospital costs by major cost-centers among enoxaparin and warfarin-treated patients in order to rationalize drug use. METHODS: An administrative database of 720,982 discharges containing ICD-9-CM coding and other data from hospitals across the U.S. was analyzed. Study patients were those whom underwent hip or knee replacement procedures, and were prescribed warfarin or enoxaparin. Length of stay (LOS), age, gender, number of diagnoses (ND), and in-hospital deaths were compared between warfarin and enoxaparin cohorts using independent t-tests and chi-squared analysis. Least-squares regression was used to