

included in a logistic regression, D and Tn remained as the only independent predictors of outcome. Tn+ lost its predictive ability in non diabetics (RR = 1.2 against T-; IC 95% = 0.4–3.9; $p = 0.77$) and increased it in diabetics (RR = 7.9; IC 95% = 1.5–41.0; $p = 0.014$). In the groups D–T– and D+T+ the percentage of combined outcome were 7.0% and 32.7%, respectively. **CONCLUSIONS:** diabetes and Tn are independent predictors of outcome in the first three months after an acute coronary syndrome without ST segment elevation. Their predictive ability is additive, so that diabetics with elevated Tn have five times the risk of non-diabetics with low Tn. The ability of Tn to predict major events seems to be lost in non-diabetic patients.

PCV2**NEW TECHNOLOGIES IN THE US MEDICARE: AN EXAMINATION OF STENT ADOPTION**

Linde-Zwirble WT¹, Ball D², Copper LM²

¹Health Process Management, Doylestown, PA, USA; ²Eli Lilly and Co, Indianapolis, IN, USA

OBJECTIVE: The use of cardiac stents is an example of a technology with both widely discussed cost concerns and widely adopted use. We examined trends in Medicare spending overall and for cardiac services from 1995 to 2000 to examine systematic response to the adoption of this new technology. **METHODS:** We used all Medicare hospitalizations from 1995 through 2000. Cases were identified for: percutaneous transluminal coronary angioplasty (PTCA), stent use, and coronary artery bypass graft (CABG) surgery. The number of cases, length of stay (LOS), costs, and total payments were calculated. All dollar amounts were inflated to 2001. **RESULTS:** Stent use in PTCA increased from 37% in 1996 to 85% in 2000. The number of PTCAs increased by 91,500 (46%) from 1995 to 2000 and the number of CABG increased by 2350 (1.3%). The combined rate for PTCA and CABG was 12.0 per thousand beneficiaries in 2000, an 18.3% increase since 1995. At \$3,000 per case, the cost for stents was \$740 million in 2000. LOS and cost for all PTCAs decreased from 4.8 days to 3.7 days, and from \$14,900 to \$13,100. The cost of CABG decreased by \$3355 per case. The cost per beneficiary for PTCA and CABG remained nearly constant and inpatient cardiac care decreased from \$756 per beneficiary in 1995 to \$698 in 2000. While changes following 1996 cost \$1.1 Billion for stents, other changes in the system saved \$6.3 billion. **CONCLUSIONS:** While the introduction of stents into common practice for cardiac care added new costs, compensating changes was induced in the system resulted in substantial savings. The direct cost of new technologies is a poor measure of expected system performance. Balanced examination of system costs and clinical performance are necessary to avoid irrational fear of short-term costs at the expense of long-term cost and care improvements.

PCV3**EFFECTIVENESS OF LIPID-LOWERING THERAPY IN PRIMARY CARE IN FRANCE**

Van Ganse E¹, Moulin P², Bertrand M³, Souchet T⁴, Pietri G¹, Yin DD⁵, de Pourville G⁶

¹Lyon Sud Hospital, Lyon, France; ²Louis Pradel Hospital, Lyon, France; ³Lille University Hospital, Lambersart, France; ⁴Merck Sharp & Dohme—Chibret, Paris, France; ⁵Merck & Co, Whitehouse, NJ, USA; ⁶INSERM U 537, Le Kremlin-Bicêtre, France

OBJECTIVE: Cholesterol lowering has been shown to reduce cardiovascular morbi-mortality. National and international (e.g. US NCEP) guidelines have defined LDL-C treatment initiation levels (TIL) and goals for patients with different levels of coronary heart disease (CHD) risk according to the number of CHD risk factors (CRF) associated to dyslipidemia or to prior CHD. The objective of this study was to measure the proportions of patients above AFSSAPS (French Drug Agency) TIL [1 CRF > 220 mg/dl; 2 CRF > 190 mg/dl; 3 CRFs > 160 mg/dl; >3 CRFs and prior CHD > 130 mg/dl] and NCEP goal in patients with different CHD risk level and treated with lipid lowering agents (LLA). **METHOD:** A total of 3173 Dyslipidemic patients managed by general practitioners were randomly selected from a French GPs computerized database. History of CHD and number of CRF (age, family history of premature CHD, smoking, hypertension, HDL-C < 0.9 mmol/L, diabetes) were documented. Percent of patients above AFSSAPS TIL and NCEP goal was defined for each level of CHD risk. **RESULTS:** Twenty-one percent of patients had a history of CHD. Using AFSSAPS guidelines the distribution of primary prevention patients according to the number of CRFs (1, 2, 3, > 3) was 1.6, 25.5, 31.7 and 20.1%, respectively. Almost 40% of CHD patients remained above TIL and the percentages of primary prevention patients above TIL varied from 3.9% for patients with 1 CRF to 46.5% for patients with >3 CRFs ($p < 0.001$). Using NCEP guidelines, percentage of patients not at goal in the different CHD risk categories were significantly higher and 74.3% of CHD patients were not at LDL-C treatment goal. **CONCLUSION:** Seventy-three percent of patients prescribed LLA were at high CHD risk. Increasing with CHD risk level, large numbers of patients were above TIL and LDL-C treatment goal. More effective interventions are needed in lipid lowering therapy.

PCV4**PREVENTION OF DEEP-VEIN THROMBOSIS AFTER TOTAL KNEE ARTHROPLASTY IN ASIAN PATIENTS: COMPARISON OF PROPHYLAXIS WITH LOW MOLECULAR WEIGHT HEPARIN AND INDOMETHACIN**

Wang CJ

Chang Gung Memorial Hospital At Kaosiung, Taiwan

OBJECTIVES: A prospective clinical study was performed to compare the efficacy of low-molecular weight