hypertension, hyperlipidemia based on the standardized interview conducted by the National Center for Health Statistics (NCHS) among adults ≥ 18 years. Descriptive statistics and multivariate logistic regression were used to determine predictors having the combined diagnosis including the following independent variables: gender, age, race, BMI status, and smoking status. Statistical analysis was performed using SAS 9.2. RESULTS: The total sample included 33,994 individuals and the combined diagnosis of hypertension and hyperlipidemia was reported in 4.49% of the sample. Of these, 61.51% were females and 41% were aged between 60-75 years. Most (73.25%) of these patients were whites and more than half (54.75%) reported to have smoked at least 100 cigarettes in their lifetime, while 34.01% were current smokers. In the multivariate model, significant odds of the combined diagnosis included female gender (OR = 0.689; 95% CI: 0.594 – 0.798; p < 0.0001), age 60-75 years vs. younger age (OR = 1.627; 95% CI: 1.296 – 2.042; p < 0.0001), Mexican American race vs. non-Hispanics (OR = 0.611; 95% CI: 0.493 – 0.768; p < 0.0007) and current smokers. (OR = 1.374; 95% CI: 1.018 – 1.75; p < 0.0001).

CONCLUSIONS: Our findings emphasize the importance of developing effective intervention strategies that help smokers quit and may reduce prevalence of hyperlipidemia with hypertension along with the accompanying cardiovascular risk.

PCV16
MANAGING GROWING POPULATION OF TYPE-2 DIABETES FROM COMMUNITY TO TEACHING HOSPITALS IN CHINA
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OBJECTIVES: Diabetes prevalence has grown rapidly in China. As the largest epidemiology and clinical outcomes assessment program, China Cardiometabolic Registries (CCMR), has been designed to establish systematic evaluation on disease progression and influencing factors. The Nationwide Assessment of CVD Risk Factors: Blood Pressure, Blood Lipid, and Blood Glucose, in Chinese Patients with type 2 Diabetes (T2D) (CCMR-3B) was one of the CCMR studies and was conducted to assess the clinical outcomes of current treatment patterns. METHODS: This was a cross-sectional study. Patients were recruited from four hospitals (tier 1, regional tier 2, and teaching hospitals tier 3) from 6 major geographic regions in China, by cardiologists, nephrologists and endocrinologist, and internal medicine. RESULTS: A total of 5099 T2D patients were included for this analysis. Across all hospitals, 55% and 34% of the patients had hypertension (HTN) or dyslipidemia (DLP), respectively, while 33% had neither. No difference was found between hospitals regarding the proportion of patients reaching target control (HbA1c<7%, BP<130/80 mmHg, LDL<2.6 mmol/L) in those who also have HTN or DLP (ranging from 4.4 % to 6.6% for the HTN group and 6.9% to8.0% for the DLP group). However a trend toward a better HbA1c control in patients without HTN or DLP (ranging from 4.4 % to 6.6% for the HTN group and 6.9% to8.0% for the DYLP group). A higher proportion of controlled HTN in larger hospitals was seen (10.7%, 11.2%, 15.4% in tier 1, 2 and 3 hospitals, respectively). A trend toward more use of multiple oral anti-diabetic drugs and insulin was also seen in larger hospitals. CONCLUSIONS: Better HbA1c control seen in larger hospitals was associated with more aggressive use of anti-diabetic treatment. The control of cardiovascular risk factors, blood glucose, blood pressure, and lipids in diabetes patients with HTN or DLP remains to be challenging in all hospital settings.

PCV17
PREDICTORS OF TIME TO DISCONTINUE BETA-BLOCKER FOLLOWING ACUTE MYOCARDIAL INFARCTION: AN ANALYSIS OF THE MEDICARE 5% NATIONAL SAMPLE DATA 2000-2009
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OBJECTIVES: To study the predictors of beta-blocker therapy discontinuation among post myocardial infarction (MI) patients enrolled in Medicare. METHODS: This is a retrospective cohort study utilizing a Medicare 5% national sample claims data from 2006 to 2007. Medicare beneficiaries with continuous Part A, B, and D enrollment in 2006–2007 were included if they were discharged following a hospitalization for MI during these years. Patients were followed for 365 days after the MI discharge date. The primary outcome was the occurrence of a MI, stroke, or death within this time period. The discontinuation of beta-blockers was defined as a gap of 90 days or more in the supply of the drug. The included patients were those in whom the beta-blocker supply had been stopped for ≥ 90 days. Descriptive statistics were calculated on patient characteristics. Predictors of discontinuation were assessed using Kaplan-Meier techniques and potential predictors of therapy discontinuation, including demographic characteristics, comorbid conditions and concomitant medications were estimated using Cox proportional hazards regression. RESULTS: Of the 2,505 subjects who met our inclusion criteria, 65.1% were females, 83.3% were Caucasian, mean age 78.6 (±8.2) years. About 15% of them discontinued therapy within six months and around 35% discontinued within a year. Males were more likely to discontinue therapy as compared to females (HR = 1.166, [1.020-1.334], p = 0.0245) and Caucasians (HR = 0.674, [0.552-0.822], p < 0.0001) vs. African Americans. The results of Cox proportional hazards regression are reported with 95%CI. CONCLUSIONS: The fully adjusted survival analysis indicated a significant negative association between time to discontinuation of beta-blockers and several patient characteristics and comorbid conditions. The most significant predictor was the patient’s gender. Males were more likely to discontinue therapy compared to females. The results of this study provide evidence to support the importance of developing strategies to enhance medication adherence following acute MI.