therapy. Persistence (remaining on therapy at 12 months after therapy initiation), mean medication possession ratio (MPR) over 12 months, and adherence (adherent to statin defined as MPR ≥ 0.8) were assessed. RESULTS: Among the 281,564 patients selected, 159,833 (56.8%) started on atorvastatin, 66,526 (23.6%) on simvastatin, 27,187 (9.7%) on pravastatin, 20,921 (7.4%) on fluvastatin, and 7,097 (2.5%) on lovastatin. The mean age was 61.3±13.2 years and 51% were male. The persistence at 12 months, mean MPR over 12 months, and adherence rate for all statins was 52.5%, 68.7%, 52.6%, respectively. The persistence rate at 12 months for patients initiated on atorvastatin, simvastatin, fluvastatin, pravastatin, and lovastatin was 54.1%, 53.7%, 49.7%, 44.8%, 41.0%, respectively (p < 0.0001 for all comparisons except for atorvastatin vs. simvastatin). The mean MPR for patients initiated on atorvastatin, simvastatin, fluvastatin, pravastatin, and lovastatin was 70.1%, 68.3%, 65.2%, 65.1%, and 62.2%, respectively (p < 0.0001 for all comparisons except for fluvastatin vs. pravastatin). Adherence for patients initiated atorvastatin, simvastatin, pravastatin, fluvastatin, and lovastatin was 54.1%, 52.6%, 48.4%, 47.7%, and 47.2%, respectively (p < 0.0001 for all comparisons except for pravastatin vs. fluvastatin, pravastatin vs. lovastatin, and fluvastatin vs. lovastatin). CONCLUSIONS: In general, patients initiated on atorvastatin are most favorable in terms of persistence, medication possession ratio, and adherence rates, followed by simvastatin, fluvastatin, pravastatin, and lovastatin patients. While there are statistical significant differences between the agents, additional studies are needed to determine if this translates to clinical differences.

EVALUATION OF THE ASSOCIATION BETWEEN HEALTH-RELATED UTILITY AND OBESITY IN HOSPITAL TREATED SUBJECTS
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OBJECTIVES: The preferred generic measure of health benefit in economic models is health-related utility. Utility provides a single measure of health-preference and has interval properties. The general pattern was non-linear (rotated J-shaped curve). Naturally, there was wide variability but definite under-utilization structure to the relationship. People had highest utility when BMI = 20kg·m⁻². Below this, utility decreases rapidly. There was a quadratic decrease in utility from BMI = 25kg·m⁻² to BMI = 35kg·m⁻² at a rate of 0.0133 utility units per BMI between BMI = 29kg·m⁻² to 30kg·m⁻², increasing to 0.0325 between BMI = 34kg·m⁻² and 35kg·m⁻². This rate of deterioration was consistent for a range of sub-group analyses: age, sex, employment status and by broad disease categories, the general association remaining the same, only the intercept varying.

CONCLUSIONS: Health-related utility is a function of obesity. These data characterise this relationship for the first time, and in a large group of subjects. The pattern of this association was consistent in all subgroups investigated, and suggests that much health benefit can be achieved by reducing obesity in the general population.

BMI, SELF-REPORTED COMORBIDITIES, AGE, AND GENDER DO NOT EXPLAIN COUNTRY-SPECIFIC DIFFERENCES IN OBESITY-RELATED QUALITY OF LIFE
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OBJECTIVE: QOL is an important outcome in the evaluation of weight loss interventions (e.g., drug therapy). The objective of this study was to determine whether there are country-specific differences in the perception of the impact of weight on quality of life (QOL) or comfort with food. METHODS: The Impact of Weight on Quality of Life Scale (IWQOL) was administered to a sample of 2144 obese individuals [Mean body mass index (BMI) =31.3, 63% ≥ 1 self-reported comorbidity, mean age = 41 years, 58% female] in Germany (n = 542), Italy (n = 503), United Kingdom (UK) (n = 539), and United States (n = 560). The IWQOL consists of 74 items forming 8 subscales: Health, Social/Interpersonal, Sexual Life, Work, Self-Esteem, Mobility, Activities of Daily Living, and Comfort with Food. For each country, Pearson correlations were calculated between demographics and IWQOL scores. To control for demographic differences in country-specific samples, differences in IWQOL scores were tested using analysis of covariance controlling for BMI, total number of self-reported comorbidities, gender, and age. RESULTS: Correlations between demographics and IWQOL subscales across countries followed a similar pattern, but the correlation coefficients calculated for Germany between most IWQOL subscale scores and BMI or total comorbidities were significantly (p < 0.05) higher. Significant (p < 0.05) country differences were found for all IWQOL scales. Pairwise comparisons showed, for example, that, compared to the other three countries, the UK sample had significantly better esteem and Mobility scores; Germany had significantly worse Social/Interpersonal scores; and Italy had significantly less comfort with food (all p < 0.05). CONCLUSIONS: Differences in the perceived impact of weight on QOL found in this study suggest the need for more research investigating cultural differences in the perception of obesity. Such differences may impact the interpretation of patient-reported outcome scores obtained in international evaluations of obesity interventions.

CARDIOVASCULAR DISEASE (including Obesity)

CARDIOVASCULAR DISEASE (including Obesity)— Health Policy Studies

MECHANICAL AND ALLERGIC ADVERSE EVENTS RELATED TO CENTRAL VASCULAR CATHETERS: EPIDEMIOLOGY IN THE MEDICARE HOSPITALIZED SURGICAL POPULATION, 2002
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