studied included age (45 vs. >45 years), hypertension, diabetes, congestive heart failure (CHF, history of heart failure or ejection fraction [EF] <40%), gender, prior MI, final diagnosis, and MI type. RESULTS: Of 1,166 consecutive patients, 1,073 were black and were included in this study. CHF was considered eligible: ‘normal coronary’, 113 (10.5%), leaving 960 patients with CHF (MI 288, 30.1%), UA (604, 62.9%). Underdiagnosed ACS [32, 3.3%], CSA [5, 3.7%]; 30% patients were diabetic. Proportion of hypertensive patients was highest among diabetic (76% vs. 34.9% non-diabetic, P<0.001). The presence of CHF in the diabetic as well as non-diabetic patients was similar. For all patients with CHF, around 40% had SVD on CAG, for diabetics, 35% patients had TVD whereas the proportion was only 24% among non-diabetics. In the linear stepwise regression, age <45 years, presence of CHF and diabetes showed significant positive correlation with the severity of CAD (p<0.05).

CONCLUSIONS: Clustering of several cardiovascular risk factors at presentation may be the worst prognosis in patients with CHF from India. Findings from this study ascertain more severe angiographic findings in diabetic patients than that in non-diabetic controls regarding the severity of CAD.

PCV10 RACIAL VARIATION IN HEART FAILURE COMORBIDITIES AND THERAPY USE IN A MEDICAID POPULATION
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OBJECTIVES: To explore the association between race, comorbidities, and therapy use among patients with heart failure (HF) in a contemporary Medicaid population. METHODS: Medicaid/prescription/enrollment records from the Maryland State Medicaid Managed Care Organization/Fee-for-services, ages 18-64, non-dual enrolled with HF diagnosis between 2001-2010, followed at least six months. We examine the effects of comorbidity and first-line therapy use across race/ethnicity. RESULTS: Among 15,764 HF patients, 60% (n=9,388) were black, 33% (n=5,158) white, 6% (n=919) other, 2% (n=299) Hispanic. Over half were female (55%), 72% older than 44 years. Prevalence in race/ethnicity. COPD (40% white, 22% black, 20% other, 11% Hispanic; p<0.001), stroke (20-22%; p=0.17), renal dysfunction (38% Hispanic, 30% black, 27%other, 22% white; p<0.001), psychological disorder (65% white, 52% black, 46% other, 37% Hispanic; p<0.001), hyperlipidemia (44% white, 39% Hispanic, 31% other, 33% black; p<0.001), chronic ischemic heart disease (47% white, 32% Hispanic, 35% other, 30% black; p<0.001), chronic ischemic heart disease/potential (76% white, 72% Hispanic, 68% white, 67% other; p<0.001), other cardiovascular disease (76-80%; p<0.05). Excluding other cardiovascular disease, the median number of comorbid conditions was 2 in each race/ethnicity. Among black, white, Hispanic and other, only 5% 5, 4, 4%, 9%, and 7.3% had zero comorbidities, and 14%, 11%, 12.4%, 15.8% had only one comorbidity, respectively. Hispanics (53%) were less likely than blacks (62%), whites (61%), or others (57%) to be prescribed ACE-inhibitor/ARB (29%), beta-blockers (26%), aldosterone antagonists (AA), and/or other cardiovascular drugs including combination nitrates/hydralazine (p<0.001).

CONCLUSIONS: Whites were most likely to be diagnosed with COPD, psychological disorder, hyperlipidemia, and chronic ischemic heart disease. Hypertension was most likely among Blacks, and renal dysfunction most likely among Hispanics. PCV11 COMORBIDITY BURDEN AMONG HEART FAILURE PATIENTS IN A MEDICAID POPULATION
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OBJECTIVES: Increasing prevalence of heart failure (HF), hypertension, and the burden of hospitalization among Medicaid patients necessitate an analysis of risk factors for heart failure hospitalization in a contemporary Medicaid population. METHODS: Claims from Maryland State Medicaid, for 14,129 non-dually enrolled, 18-64 years old with a diagnosis for HF between 7/1/05-12/31/09, followed for at least six months. We examine the effects of comorbidity and first-line therapy use across race/ethnicity. VTE recurrence was used to test non-proportional risk of hospitalization over the follow-up period. We report numbers needed to treat with first-line therapy to prevent one hospitalization annually. RESULTS: Most patients were >45 years (71%), female (56%), and black (60%). Use prevalence was: beta-blockers (26%), ACE-inhibitors/ARB (29%), aldosterone antagonists (AA), and/or other cardiovascular drugs including combination nitrates/hydralazine (37%). Nearly all (98%) were diagnosed with one or more comorbidities. Relative risk (95% CI) for any hospitalization was 1.43 (1.36-1.51) renal dysfunction, 1.40 (1.31-1.50) other cardiovascular disease, 1.33 (1.26-1.40) COPD, 1.28 (1.22-1.35) chronic ischemic heart disease, 1.23 (1.20-1.26) diabetes, 1.11 (1.05-1.17) hypertension, 0.81 (0.77-0.85) hyperlipidemia, 0.77 (0.73-0.81) psychological disorder, 0.73 (0.70-0.81) ACE inhibitor/ARB, 0.83 (0.79-0.87) beta-blocker, 0.76 (0.72-0.80) other cardiovascular drugs. AA and/or nitrates/hydralazine combination therapy had no impact on VTE outcomes in the overall group. CONCLUSIONS: Our study quantifiably mitigates risk of hospitalization. Growing ranks of state Medicaid plans and other entitlement programs call for more deliberate, proactive and cost-effective disease and risk management plans.

PCV13 RISK FACTORS IN HOSPITALIZED PATIENTS WITH ACUTE VENOUS THROMBOEMBOLISM: A CLAIMS DATABASE ANALYSIS
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OBJECTIVES: Venous thromboembolism (VTE) includes deep-vein thrombosis and pulmonary embolism (PE), with a considerable risk of recurrence and mortality. This study examined the recurrence rate and associated risk factors in hospitalized patients with acute VTE in the US clinical practice setting. METHODS: Adult patients with VTE were selected from the linked MarketScan and Truven Health Data1. Discharge database by ICD-9-CM 451.4, 453.1 between 07/01/2006-12/31/2011. The first hospitalization with a diagnosis of VTE (ICD-9-CM: 451-453, 671.3, 671.4, 671.9, 451.1, 673.2, or 673.8) was designated as index hospitalization. Patients were required to have at least 6 months continuous enrollment and have no VTE diagnosis in the 6 months prior to index hospitalization. Patients were followed until the earliest of VTE recurrence, death, disenrollment, or the end of study. VTE recurrence was defined as re-hospitalization with at least 1 day after discharge from index hospitalization. Recurrence was used to model time to recurrence and examine demographic and clinical factors associated with recurrence. RESULTS: A total of 957 patients were eligible for the study, including 570 patients with DVT only (59.6%), 237 with PE only (24.7%), and 150 with both DVT and PE (15.7%). Mean age was 62.8 years (SD=15.2), and 432 were male (45.1%). Mean follow-up time was 23.1 months. During follow-up, 146 patients recurred, with a recurrence rate of 15.3%. The average time to recurrence was 20.1 months (median=15.4). Number of comorbids associated with Charlson Comorbidity Index was independently associated with increased risk for VTE recurrence (hazard ratio [HR]: 1.12, 95%CI=1.05 – 1.20). CONCLUSIONS: Our study was the first to examine recurrence and its economic outcomes associated with VTE treatment patterns.

PCV14 IMPACT OF INITIATING STATIN THERAPY AT A HIGH DOSE – A RETROSPECTIVE OBSERVATIONAL STUDY POPULATIONS IN THE UNITED KINGDOM
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OBJECTIVES: High-dose statin therapy has been reported to be associated with increased risk of side effects, which may reduce treatment adherence and thereby reduce long-term cardiovascular (CV) benefits. This study assessed the association between initial statin dose and treatment adherence and persistence and its impact on CV outcomes in the overall and sub-population with prior CV events. METHODS: An observational, retrospective study was conducted in a UK linked database (CPRD) comprising primary care, secondary care (Hospital Episode Statistics), and
mortality data. Study cohort was statin-naïve patients initially prescribed statin therapy from January 2003-July 2011, and registered within the practice for ≥1 year preceding statin initiation. High-dose was defined as simvastatin 80mg, fluvastatin 40mg, pravastatin 10mg. Adjusted logistic regression models were used to predict factors associated with discontinuation and CV event risk. RESULTS: Only 2% (4,744/21,808) of patients started on a high-dose statin (4,396/4,796, 93%) on an initial dose of 80mg. Adherence was high based on prescription medication possession ratio for high-dose statins (98.9%, SD:0.08) and low-dose (99.5%, SD:0.01). Initial dose was not a predictor of discontinuation in the overall population (OR:0.96 95%CI:0.91-1.02), but in patients with CV history, high-dose initiation was associated with lower discontinuation risk (OR:0.87 95%CI:0.78-0.96). In the overall population increased CV event rates were associated with initiation of high-dose statin (OR:1.05 95%CI:1.02-1.08), greater Framingham risk (OR:2.07 95%CI:1.73-2.41), and myocardial infarction (MI) (OR:4.29 95%CI:3.56-5.17). In the CV subgroup, only prior MI was associated with increased CV event risk (OR:1.26 95%CI:1.03-1.55). CONCLUSIONS: Initial high-dose statin was not associated with lower adherence or persistence, among patients with CV history, risk of discontinuation was significantly lower. The association of initial high-dose statin treatment with higher CV event rates may be due to background risk factors leading to use of high-dose statin.

PCV15 EFFICACY AND SAFETY OF ADDITIONAL LINEAR ABLATION WITH PULMONARY VEIN ISOLATION FOR THE RHYTHM CONTROL OF ATRIAL FIBRILLATION: A META-ANALYSIS OF RANDOMIZED CONTROLLED TRIALS

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OBJECTIVES: Many new catheter ablation (CA) methods based on pulmonary vein isolation (PVI) have been developed. The aim of this study was to assess the benefits and harms of additional linear ablation with PVI/ circumferential pulmonary vein ablation (CPVA) in comparison with PVI/CA in patients with AF. METHODS: Ovid-Medline, Ovid-EMBASE, Cochrane library, and seven Korean medical databases were searched to identify studies through May, 2012. To assess the quality of randomized controlled trials (RCTs), the Cochrane risk of bias tool was used. Data were independently extracted by two reviewers using a standardized form. Disagreements between reviewers were resolved by discussion and consensus. The dichotomous data were presented as pooled relative risk (RR), representing an association of treatment effect. Relative risks were calculated using a random-effects model. RESULTS: A total of 12 RCTs (1,226 patients) were included and of poor quality. Differences between groups of all-cause mortality were not reported in 12 RCTs. PVI/CPVA plus additional linear ablation, in comparison with PVI/CPVA, increased freedom from atrial tachycardia (AT)/AF (RR 1.10, 95% CI 0.97-1.25, I2=64%) in 12 RCTs, but there was insignificant and moderate heterogeneity among trials. The RR of stroke, transient ischemic attack (TIA) or thrombo-embolic events across both groups was 0.75 (95% CI 0.50-1.20, I2=0%). Fewer complications and adverse events were reported in the trials and there were no differences. CONCLUSIONS: The results of meta-analysis showed a trend of favor of PVI plus additional linear ablation for freedom from AT/AF in comparison with PVI/CA. Adequately powered, and long-term clinical trials are warranted.

PCV16 EFFECT OF STATINS FOR PRIMARY PREVENTION OF CARDIOVASCULAR DISEASE AMONG ELDERLY

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OBJECTIVES: Statin treatment has been shown to be effective in secondary prevention for vascular events among patients with established cardiovascular disease (CVD). However, its effectiveness of primary prevention for CVD in the elderly is unknown. The aim of this study was to examine whether statins are effective in reducing CVD risk among the elderly without medical history of CVD. METHODS: We used population-based National Health Insurance Research Database to conduct a retrospective cohort study. We identified 5374 lipid-lowering drugs users aged over 55 years old who were first-time users of statin or lowering cholesterol medications for primary prevention purpose between year 2000 and 2003. We used Cox proportional hazard model to analyze the risk of coronary artery heart disease, cerebrovascular disease or peripheral arterial occlusion disease during follow-up time. Interaction terms of age and statins were included in the model to examine the heterogeneous effect of statins across age groups. We used propensity score to adjust the potential self-selection effect of statin treatment. We used propensity score to adjust the potential self-selection effect of statin treatment. RESULTS: The cumulative relative risk for total bleeding events with Dabigatran versus Warfarin was 1.1 (95% CI 1.08-1.12). CONCLUSIONS: Meta-analysis shows that Dabigatran has a slightly lower rate of total bleeding events compared to Warfarin.