PCN38

TREATMENT PATTERNS OF PATIENTS WITH METASTATIC BREAST CANCER AFTER FAILURE TO ANTHRACYCLINE AND TAXANE UNDER THE BRAZILIAN PUBLIC HEALTH CARE SYSTEM PERSPECTIVE

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OBJECTIVES: To identify current treatment patterns of care for patients with metastatic breast cancer (MBC), refractory to anthracyclines and taxanes, treated under the perspective of the Brazilian public health care system. **METHODS:** A cross-sectional study of patients from 4 public hospitals in south and southeast region of Brazil. All patients ≥18 years diagnosed with MBC who had progressed following treatment with an anthracycline and a taxane between 2003 and 2006, with at least 4 months of survival after metastatics disease were included. Data was collected from their medical charts. **RESULTS:** 217 patients with an average age of 52 years (25–80 years old) were included in the analysis. Among patients with HER2 testing (59%), 40% were HER-2 positive and among patients with hormone receptor testing (89%), 51% were hormone receptor positive. 85% of the patients had information regarding treatments received in their medical charts. The most frequent chemotherapy regimens prescribed following use of anthracycline and taxane ("first line") were capecitabine (52.7%), gemcitabine + cisplatin (17.4%), and tamoxifen (8.7%). Second line treatment was prescribed for 58% of patients: gemcitabine + cisplatin (23.4%), capecitabine (20.6%), vinorelbine (14.0%), tamoxifen (12.1%), paclitaxel (4.7%) and letrozol (4.7%). The median number of treatment regimens was 2, with a range of 1 to 6. The average resources utilization per patient/year included 1.85 plain thorax x-rays, 0.57 thorax CTs, 1.06 abdominal ultra-sounds, 0.46 abdominal CTs and 0.86 bone scintigraphies. The average survival of patients after first breast cancer diagnosis was 44.8 months (SD: 35.8; median: 32.0) and after first diagnosis of metastasis was 22.4 months (SD: 20.0; median: 16.1). The average survival post progression to anthracyclines and taxanes was 12.7 months (SD: 12.4; median: 8.4). **CONCLUSIONS:** Within the Brazilian public health care system, the most frequently used first and second line treatments, for MBC.

CARDIOVASCULAR DISORDERS – Clinical Outcomes Studies

PCV1

PREDICTED CARDIOVASCULAR EVENT REDUCTION WITH THE CO-ADMINISTRATION OF FENOFIBRIC ACID AND LOW- OR MODERATE-DOSE STATINS IN HISPANIC PATIENTS WITH MIXED DYSLIPIDEMIA

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OBJECTIVES: To estimate predicted 3-year total CVE rates (per 1000) in Hispanic patients with mixed dyslipidemia treated with fenofibric acid and a statin compared to statin monotherapy. **METHODS:** A disease outcomes model was used to predict 3-year total CVE rates (per 1000) using baseline lipid, and lipid efficacy, data of Hispanic patients with mixed dyslipidemia from a pooled analysis of three large, double-blind, Phase III, randomized controlled trials that evaluated the efficacy and safety of fenofibric acid 135 mg combined with low-dose statin (LDS) (simvastatin 20 mg, rosuvastatin 10 mg, atorvastatin 20 mg) or moderate-dose statin (MDS) (simvastatin 40 mg, rosuvastatin 20 mg, atorvastatin 40 mg) compared to equivalent dose statin monotherapy. Risk for primary and secondary CVE including myocardial infarction (MI), angina pectoris, and stroke were based on published risk equations from the Framingham Heart Study. Additional risk attributable to elevated TG levels is estimated using hazard ratios from the Copenhagen Heart Study. **RESULTS:** Co-administration of fenofibric acid and LDS or MDS was predicted to reduce 3-year total CVE rates by 37% (from 33 to 21 per 1000) and 22% (from 31 to 24 per 1000) compared to LDS and MDS monotherapy, respectively. The majority of CVE were attributable to MI, followed by angina and stroke in all treatment groups. **CONCLUSIONS:** These data suggest that the co-administration of fenofibric acid and LDS or MDS may result in a 37% and 22% reduction in 3-year total CVE rates in Hispanic patients with mixed dyslipidemia.

PCV2

PREDICTED OPTIMAL LIPID VALUE ATTAINMENT RATES WITH THE CO-ADMINISTRATION OF FENOFIBRIC ACID AND A STATIN COMPARED TO STATIN MONOTHERAPY IN HISPANIC PATIENTS WITH MIXED DYSLIPIDEMIA

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OBJECTIVES: To predict multiple OLV attainment rates (per 1000) with the co-administration of fenofibric acid and low-dose statin (LDS) or moderate-dose statin (MDS) compared to equivalent dose statin monotherapy in Hispanic patients with mixed dyslipidemia. **METHODS:** A dyslipidemia outcomes model was used to predict multiple OLV attainment rates (defined as achieving any of 3 of 4 targets: total-C, LDL-C, HDL-C, or TG) among a cohort of 1000 Hispanic patients with mixed dyslipidemia. The model simulates baseline lipid values to reflect natural co-variation using data from the National Health and Nutrition Examination Survey (1999–2004), simulates post-treatment improvements to reflect the lipid efficacy of each treatment comparator, and then compares post-treatment improvements to US guideline-based lipid targets (LDL-C < 100 mg/dL, TG < 150 mg/dL, total-C < 200 mg/dL; HDL-C > 40 mg/dL). Baseline lipid and lipid efficacy data for the Hispanic population were from a pooled analysis of three large, double-blind, Phase III, randomized controlled trials evaluating the efficacy and safety of fenofibric acid combined with LDS or MDS as compared to statin monotherapy at equivalent doses. **RESULTS:** Compared to statin monotherapy, co-administration of fenofibric acid with LDS and MDS is predicted to increase multiple OLV attainment rates by 63% (546 to 890 per 1000) and 18% (630 to 745 per 1000), respectively. Fenofibric acid, when co-administered with a statin, is predicted to result in higher proportions of patients achieving individual TG and HDL-C target levels; while statin monotherapy treatment is predicted to result in higher proportions of patients achieving LDL-C targets. **CONCLUSIONS:** These data suggest that co-administration of fenofibric acid and LDS or MDS may enable more patients to achieve multiple OLV compared to statin monotherapy in Hispanic patients with mixed dyslipidemia.

PCV3

HIGH-DENSITY LIPOPROTEIN CHOLESTEROL AND RISK FOR MAJOR CARDIOVASCULAR EVENTS IN MEN AND WOMEN

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OBJECTIVOS: Evaluar la relación entre los niveles de HDL-C y el riesgo de eventos cardiovasculares mayores (ECVM) como desenlace compuesto incluyendo infarto del miocardio, angina, accidente cerebrovascular, y revascularizacion coronaria. **METODOLOGÍAS:** Análisis de cohorte restrospectivo de paraclínicos registrados la base de datos Ingenix LabRx. Se incluyeron pacientes con edad ≥50 años y perfil lipidico completo (fecha índice) entre el 1 de enero de 2000 y el 31 de diciembre de 2003. Todos los sujetos fueron enrolados en los 6 meses, antes del perfil lipidico y 12 meses después, terminando el seguimiento cuando se presentara un ECVM o terminara su plan de salud. Modelos de regressión Cox fueron utilizados para evaluar el riesgo de presenter ECVM, controlando por ECVM previos y otros factores de riesgo cardiovascular. Hazard ratios (HR) multifactoriales fueron ajustados para ECVM con base en las categorías de HDL-C: 46–50 mg/dL, 40–45 mg/dL y < 40 mg/dL versus HDL-C > 50 mg/dL y HDL-C: 36–40 mg/dL, 30–35 mg/dL y < 30 mg/DL versus HDL-C > 40 mg/dL en mujeres y hombres, respectivamente. **RESULTADOS:** Un total de 255,953 pacientes cumplieron los criterios de inclusión; la mayoria (52%) fueron mujeres. En general, el riesgo de un ECVM se incrementó con cada 5 mg/dL de disminución en los niveles de HDL-C. Entre las mujeres, el HR para cada categoría fue de: 1.24 (95% IC, 1.16 a 1.34), 1.32 (95% IC, 1.23 a 1.41), y 1.51 (95% IC, 1.40 a 1.64). Entre los hombres los HR fueron: 1.22 (95% IC, 1.16 a 1.28), 1.33 (95% IC, 1.26 a 1.40), 1.57 (95% IC, 1.44 a 1.70). **CONCLUSIONES:** En esta cohorte de población general, la categoría de HDL-C más baja se asoció con un incremento en el riesgo de un ECVM de un 51% y 57% en mujeres y hombres, respectivamente, comparado con la categoría de HDL-C más alta.

PCV4

COST AND OUTCOME ANALYSIS COMPARING PTCA & CABG IN LOW AND HIGH RISK PATIENTS

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OBJECTIVES: The study was conducted at a private tertiary care hospital with the objective of performing a cost and outcome analysis of low and high risk patients who had undergone PTCA (n = 148; 58.96%) and CABG (n = 103; 41.03%). **METHODS:** Parameters like length of stay, post surgical survival, post surgical complications, readmissions were assessed. **RESULTS:** The average length of stay for low and high risk patients who had undergone PTCA was 3.61 and 3.87 days, respectively and in case of CABG it was 10.94 and 10.31 days, respectively. The readmissions for PTCA patients within 1 year was 34 (22.97%) and only 5 (4.85%) for CABG patients. The average cost for low and high risk patients in PTCA was INR2,30,000/- and INR2,87,000/- respectively, and INR2,00,000/- and INR2,30,000/- in case of CABG. The average cost for PTCA (readmissions) with a follow up of 1 year was INR4,22,000/-. The results showed that CABG had a higher benefit-to-cost ratio (0.53) as compared to PTCA (0.21). PTCA was associated with shorter hospital stay and mortality (2.85%) when compared to CABG (7.84%). **CONCLUSIONS:** The differences between PTCA and CABG for both low and high risk patients in cost, survival rate and quality of life were matching but 1 year follow up showed that recurrent procedures were required in case of PTCA. The results of this limited study need to be extrapolated in a very cautious manner. A selected set of patients are recommended for PTCA who require coronary intervention and there are reports showing that PTCA had better survival than CABG in patients with single vessel coronary artery diseases (CAD); whereas, CABG produced better survival than did PTCA in patients with severe, triple vessel CAD.

CARDIOVASCULAR DISORDERS – Cost Studies

PCV5

PROPHYLAXIS OF HEART TRANSPLANTATION REJECTION: FINANCIAL IMPACT ANALYSIS BY BRAZILIAN PUBLIC HEALTH CARE SYSTEM AND A REVIEW OF ECONOMIC EVALUATIONS STUDIES OF EVEROLIMUS, MMF (MYCOPHENOLATE MOFETIL) AND AZATHIOPRINE

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OBJECTIVES: To analyze the financial impact of reimbursing everolimus, azathioprine and MMF in heart transplantation by Brazilian Ministry of Health. To review