chloride with lisinopril (major), furosemid with digoxin (moderate), and warfarin with levofloxacin (moderate). CONCLUSIONS: Potential DDIs were common in this elderly population with multiple comorbidities. While some drug combinations with potential DDIs may be clinically appropriate, they require ongoing monitoring to ensure patient safety. The large number of potential DDIs identified with these data warrants future research into the prevalence of appropriate monitoring when potentially interacting drug combinations are prescribed. This study demonstrates the utility of using prescription claims databases for identifying specific sub-populations of patients at high risk for potential DDIs and targeting appropriate areas for intervention.

COLD AND INACTIVITY: THE ULTIMATE FACTORS FOR HEART ATTACK
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OBJECTIVES: Heart attack is diagnosed in approximately 20,000 cases annually in Hungary, half of which leads to death in one year. In our study we investigated, how meteorological factors influence the figures of heart attack, whether there is a parallel relationship between weather fronts and heart attack during the study period. METHODS: We analyzed data of patients admitted to hospitals in Hungary between 2000 and 2004, with the diagnosis of heart attack. During the study period 81,956 cases were recorded. We categorized patient subgroups based on the day, month and year of the admission, and the gender and age of the patients. The National Health Insurance Fund and the National Weather Service provided us with the appropriate data. Statistical analysis was performed using ANOVA and chi2-probe. RESULTS: During the study period we found a correlation between the incidence of heart attack cases and meteorological factors. In spring, we observed significantly more heart attacks than in other seasons (p < 0.01). Cold weather fronts in spring and summer positively correlated with heart attack incidence, while in autumn and winter the warm weather fronts in spring and summer positively correlated with the number of cases on Monday and a drop during the weekend. During weekend days markedly less cases were recorded comparing to weekdays (p: 0.110 MT[0.108;0.112] vs. p: 0.155 MT[0.153;0.158], respectively). Furthermore, there was a peak in the number of cases on Monday and a drop during the weekend.
CONCLUSIONS: Environmental temperature has an effect on the change in figures of heart attack cases, thus, we believe, it plays an important role in the disease.

EFFECT OF ENVIRONMENTAL TEMPERATURE AND WORKDAYS ON HEART ATTACK FIGURES
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OBJECTIVES: We investigated, whether environmental temperature and workdays, beyond the well known risk factors, might have an impact on the figures of heart attack cases in Hungary. METHODS: Data analysis and retrospective data collection was used among patients diagnosed with heart attack at the Cardiology Department of the University of Pecs, Hungary in the time period between January 1, 2000 and December 31, 2004. Weather data were obtained from the Local Service of the National Weather Institute, Pecs, Pogany Airport Base. In the time period under investigation, 81,956 patients were admitted with the above diagnosis. Analysis of variance and linear regression analysis were used as statistical methods. RESULTS: We found that the environmental temperature influenced the incidence of heart attack in 0.79%. This result was found to be significant (p < 0.01). Above 0°C there were more heart attack cases diagnosed than below it. We observed a steady decrease in the incidence from Monday to weekend. During weekend days markedly less cases were recorded comparing to weekdays (p: 0.110 MT[0.108;0.112] vs. p: 0.155 MT[0.153;0.158], respectively). Furthermore, there was a peak in the number of cases on Monday and a drop during the weekend.
CONCLUSIONS: Environmental temperature has an effect on the change in figures of heart attack cases, thus, we believe, it plays an important role in the disease.
hazard a significant difference.

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| **EFFECT OF WEATHER CONDITIONS ON THE MORTALITY OF HEART ATTACKS IN HUNGARY**
Kriszbacher I, Boncz I, Sebestyen A, Vas G, Bodis J
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OBJECTIVES: Several reports have already proved that the number of deaths related to acute myocardial infarction (AMI) shows a seasonal variation, with a peak in winter, and a lowest rates during the months of summer. The effects of meteorological variables on the human organism have been studied for more than fifty years, and changes in the number of AMI events have been related to both cold or warm temperatures.

METHODS: The number of cardiac mortality (N = 16,160) in Hungary shows a steadily decreasing tendency between 2000 and 2005, with a seasonal variation regardless of age or sex.

RESULTS: The peak period of AMI mortality was during the months of spring, with a lowest value during the summer. There was a significant difference between seasons (F = 3.027; p < 0.05). The daily average of cardiovascular mortality during each season was the following: 8.48 during spring, 7.23 during the summer, 7.79 during autumn, and 7.76 during winter. The sharp temperature increase during spring, and the similarly significant decrease of temperatures during autumn, both have an increasing effect on heart attack related mortality. Studying the moving average of AMI mortality (k = 7), and the relation with the daily average temperature of the preceding 7 days, we have found a medium value negative correlation (r = -0.466, p < 0.01). Considering the moving average of deaths (k = 7) and the average daily temperature of the preceding seven days above and below 20 Celsius, we have found a significant difference.

CONCLUSIONS: The mortality of AMI may be related to the internal biological rhythm of the organism, and also to such external conditions as weather. The combined effect of certain meteorological factors, such as a sudden temperature or atmospheric pressure change, may be considered as a risk factor in the mortality of a heart attack.

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| **TOLERABILITY OF ROSUVASTATIN 40 MG COMPARED TO 20 MG IN THE TREATMENT OF HYPERCHOLESTEROLAEMIA: EVIDENCE FROM RANDOMISED CONTROLLED TRIALS**
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OBJECTIVES: To compare the tolerability of rosuvastatin 40 mg with 20 mg in the treatment of patients with hypercholesterolaemia based on a meta-analysis of 9 randomised controlled trials (n = 3314) from the CRESTOR clinical trial programme.

METHODS: Data were extracted on the following organ systems: Muscle (rhabdomyolysis, myopathy, myalgia, creatine kinase increase); Liver (liver failure, hepatitis, abnormal liver function [ALT increase]); Renal (renal failure, serum creatinine increase, haematuria, proteinuria). The events analysed were all treatment-emergent adverse events rather than treatment-related adverse events to provide an objective evaluation of any possible difference in risk between rosuvastatin 40 mg and 20 mg. Summary effect estimates were calculated as risk difference (RD) in meta-analyses using a fixed effects model. RD is an absolute measure of the difference in tolerability, i.e. percentages reported are the risk of an event with rosuvastatin 40 mg compared to 20 mg (positive values indicate higher, negative values lower).

RESULTS: The event rates were low for all outcomes. For rhabdomyolysis, liver failure, and hepatitis there were no events with either rosuvastatin 40 mg or 20 mg. Other outcomes had the following results—Muscle: myopathy 0.006% (95%CI: -0.266% to 0.279%, p = 0.9631), myalgia 0.216% (95%CI: -0.874% to 1.306%, p = 0.6971), creatine kinase increase 0.424% (95%CI: -0.099% to 0.947%, p = 0.112); Liver: abnormal liver function 0.189% (95%CI: -0.415% to 0.793%, p = 0.540); Renal: renal failure -0.023% (95%CI: -0.296% to 0.251%, p = 0.871), serum creatinine increase 0.033% (95%CI: -0.239% to 0.305%, p = 0.811), haematuria -0.015% (95%CI: -0.372% to 0.342%, p = 0.936), proteinuria 0.070% (95%CI: -0.274% to 0.415%, p = 0.689). Sensitivity analysis, using random effects model, demonstrated no difference in any of the outcomes except myalgia, for which there was a small numerical difference (0.420%; 95%CI: -1.332% to 2.172%; p = 0.638).

CONCLUSIONS: There is no evidence from randomised controlled trials to suggest any difference in tolerability between rosuvastatin 40 mg and 20 mg.