PCAS was 3.3%, the overall adverse event rate was 3.1% and the 30-day mortality rate was 1.2%. A chi-square analysis of the adverse event rates revealed no clear relationship between the study group and proportion of adverse events among all 18 studies ($\chi^2 = 14.6, p > 0.10$). Multiple sensitivity analyses were conducted; however, no relationship between the study group and proportion of adverse events resulted ($\chi^2 = 11.2, p > 0.10$). **CONCLUSION:** Although practitioners await stronger evidence, this study demonstrates the relatively low rates of adverse events in PCAS relative to CAS alone and the warranted use of PCAS.

**PCV14**

A COMPARISON OF THE RISK OF ADVERSE THROMBOEMBOLIC AND BLEEDING EVENTS BETWEEN SUBJECTS TREATED AND NOT TREATED WITH WARFARIN

Riedel A1, Hauch O2, Harley C1, Nelson M1, Wygant G2, Reynolds MW2

1Ingenix, Eden Prairie, MN, USA; 2AstraZeneca, LP, Wilmington, DE, USA

**OBJECTIVE:** This study was conducted to assess the risk of thromboembolic and bleeding events among atrial fibrillation patients treated with warfarin. **METHODS:** Using claims data from a large commercial health plan, patients with chronic atrial fibrillation were identified based on medical claims with diagnosis codes 427.31 and 427.32 from 1998 through 1999. Patients with valvular disease were excluded. Cox proportional hazards analysis was used to compare risk of venous, arterial, intracranial, and total thromboembolic events between warfarin exposed and unexposed subjects. Risk of bleeding events was also compared. **RESULTS:** A total of 6764 subjects were retained for analysis; of these 3541 (52.4%) were exposed to warfarin during the follow-up period. Among thromboembolic events, treated subjects were significantly less likely to experience arterial events compared to non-treated subjects (HR: 0.710, CI: 0.540–0.934). No differences in the risk of venous or intracranial events were found, nor in the risk of thromboembolic events overall. Use of warfarin significantly increased the risk of minor bleeding events (HR: 3.600, CI: 2.537–5.109), and all bleeding events (HR: 1.502, CI: 1.289–1.749). **CONCLUSIONS:** A large number of atrial fibrillation patients are not being treated with warfarin. After adjusting for baseline characteristics, the risk of thromboembolic events in this population was not significantly different between those exposed and unexposed to warfarin. There was a significant increase in the risk for minor and total bleeding events among patients treated with warfarin. Both observational studies and decision analytic models have indicated that the outcomes of warfarin therapy is highly dependent of how it is managed. The present study seems to indicate that there is a significant gap between the performance of warfarin in reducing the risk of thromboembolic events as shown in tightly controlled clinical trials or coagulation clinics versus what is achievable in general practice.

**CARDIOVASCULAR DISEASE (including Obesity)**

**CARDIOVASCULAR DISEASE (including Obesity)—Cost Studies**

**PCV15**

ECONOMIC EVALUATION OF GLYCOPROTEIN IIB/IIIa ANTAGONISTS IN DIABETIC PATIENTS WITH ACUTE CORONARY SYNDROME UNDERGOING PERCUTANEOUS CORONARY INTERVENTIONS WITH STENTING

Mittmann N1, Brown A1, Seung SJ1, Noorani H2, Mensinkai S3, Cohen E1, Riseborough N1, Oh P1, Tang Z2

1University of Illinois at Chicago, Chicago, IL, USA; 2University of Chicago, Chicago, IL, USA

**OBJECTIVES:** Diabetic patients have a higher risk of coronary artery disease. Percutaneous coronary intervention (PCI) with stenting has become the standard of care to repair coronary vessel blockage. However, stenting increases the risk of thrombus formation at the implantation site. Platelet glycoprotein IIb/IIIa antagonists drug reduce this risk. This study examines whether abciximab and eptifibatide are cost-effective as adjunct therapies in diabetic patients undergoing PCI with stenting. **METHODS:** Included were diabetic patients undergoing elective or urgent PCI with stenting. Clinical outcome data was extracted from the published EPISTENT and ESPRIT trials. Abciximab (N = 335) and eptifibatide (N = 419), with stenting, were compared to a treatment group of stent-only patients. Short-term (one year) and long-term (survival-Markov model) decision analytic models (DATA 4.0) were constructed from a Canadian provincial health system perspective. Results are reported in 2001 Canadian dollars and presented on a per person basis. A 5% discount rate was used. Probabilistic sensitivity analysis (SA) was done using Crystal Ball. **RESULTS:** For abciximab + stent, incremental costs were higher (+$81) but clinical outcomes were better (~18.5%) major adverse cardiac events [MACE] and ~3% mortality) relative to the stent-only group. The incremental cost-effectiveness ratio for abciximab was $438 per MACE avoided and $2700 per death avoided. Abciximab + stent patients had 0.22 more adjusted life years (LYs) than the stent-only group so the incremental ratio was $368 per adjusted LYs gained. When compared to the stent-only group, eptifibatide + stent was dominant in terms of costs (Incremental = $166), MACE rate (Incremental = 7.1%) and mortality (Incremental = 2%) over the short-term. There was a 0.22LY increase for eptifibatide. SA indicated that drug acquisition and procedure costs were the major cost drivers. Results were robust. **CONCLUSIONS:** Eptifibatide and abciximab (+stenting) are considered cost-effective in the treatment of diabetic patients undergoing PCI.