The reported criteria used for determining SAS, CK testing upon MRS and trial of rechallenge, 61% (RAC 50–67%) reported discontinuing the statin to test whether statins. Most clinicians (average 74%; RAC 63–85%) reported rechallenging patients statins are consistent with the latest EASCPS, although routine CK testing and statin consideration MRS in patients receiving statins to indicate SAS. Across countries, an average of 69% of clinicians reported testing for elevated creatine kinase (CK) levels.

**OBJECTIVES:** To establish whether identification of patients with statin-associated symptoms (SAS), particularly muscle-related symptoms (MRS) in real-world practice is aligned with the latest clinical consensus. **METHODS:** A web-based survey was conducted in France, Germany, Italy, the Netherlands, Poland, Spain, Sweden, and the UK in February–March 2016. Sixty clinicians per country answered questions about clinical criteria used to identify patients with SAS. These criteria from real-world practice were compared with those recommended in the 2015 European Atherosclerosis Society Consensus Panel Statement (EASCPS) to explore their alignment. **RESULTS:** Overall, 319 clinicians (76% cardiologists) completed the survey. Almost all clinicians (average 98%; range across countries [RAC] 97–100%) saw and considered MRS in patients receiving statins to indicate SAS. Across countries, an average 68% (RAC 59–77%) of the reported testing for elevated CK levels in all patients newly prescribed statins; an average of 52% reported testing in patients who displayed MRS. On average, 77% of clinicians (RAC 68–85%) reported trying ≥2 statins and both considering MRS (RAC 57–73%) tried ≥3 statins. Most clinicians (average 74%; RAC 63–85%) reported rechallenging patients with the same statin to confirm whether MRS were SAS. Of those who did not rechallenge ≥61% (RAC 50–78%) reported discontinuing the statin when other MRS resolved, and an average of 38% (RAC 32–45%) reported using a combination of rechallenge, discontinuing, and lowering the dose of statin to confirm SAS. Of the reported criteria used for determining SAS, CK testing upon MRS and trial of ≤3 statins are consistent with the latest EASCPS, although routine CK testing and statin rechallenge are not fully consistent. **CONCLUSIONS:** This survey suggests that the clinical criteria used to identify patients with SAS across eight European countries are broadly consistent with the current clinical consensus in Europe.

**PCV154 MANAGING PATIENTS WITH STATIN-ASSOCIATED SYMPTOMS: DOES REAL-WORLD CLINICAL PRACTICE ALIGN WITH CLINICAL GUIDELINES AND HTA RECOMMENDATIONS IN EUROPE?**

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**OBJECTIVES:** To compare the management of statin-treated patients with hypercholesterolemia with the associated symptoms (SAS) in real-world practice across eight European countries with the latest European Atherosclerosis Society Consensus Panel Statement (EASCPS) and decisions of national health technology assessment (HTA) agencies. **METHODS:** A web-based survey in France, Germany, Italy, the Netherlands, Poland, Spain, Sweden, and the UK in February–March 2016. Sixty clinicians (specialists and general/family physicians, 2:1 ratio) per country answered questions about the management of patients with SAS. Targeted literature search and extraction of data were performed. The primary study population was patients with SAS. The study population was divided into four attitudinal groups based on their BMQ score: (1) “Approving,” (2) “Indifferent,” (3) “Refractory,” and (4) “Critical.” (1) “Approving” patients were those who believe in the benefits of medications and are willing to perform the diagnostic tests to identify SAS. (2) “Indifferent” patients were those who were indifferent about the use of medications and diagnostic tests. (3) “Refractory” patients were those who believe in the benefits of medications and are unwilling to perform the diagnostic tests to identify SAS. (4) “Critical” patients were those who believe in the harm of medications and diagnostic tests. **METHODS:** Retrospective study of all VTE events between 1 April 2008 and 31 March 2012 in linked Clinical Practice Research Datalink/Hospital Episode Statistics databases. We defined VTEs by Read or ICD-10 codes with anticoagulant prescription within 45 days after VTE or hospital discharge. We used multivariate Cox regression to identify factors associated with AC duration (event–end of AC).

**RESULTS:** Of 113,353 VTEs, 45.0% were females and 47.8% were men. Mean patient age was 69.3 years. Median AC duration was 219 days. In the Cox model, previous VTE was strongly associated with increased AC duration (HR 0.46 [95%CI 0.42–0.50]). Other factors associated with longer AC duration were age >65 yr (HR 0.41, 95%CI 0.39–0.43), female gender (HR 0.60, 95%CI 0.58–0.63), and comorbidity (HR 1.22, 95%CI 1.19–1.25).

**CONCLUSIONS:** In recent practice in England, most patients received more than 6 months of AC therapy after VTE. Factors associated with prolonged AC duration were age >65 yr, female gender, and comorbidity. However, these factors were not significant differences between IG and IG and for both Necessity and Concern score (t=5.74, p<0.001; t=7.86, p<0.001 respectively). Patients were divided into four attitudinal groups based on their BMQ results and data showed that t12 88.3% of IG patients were “Accepting” and 15.5% were “Indifferent.” None “Skeptic” patients were found in the IG and only 1.2% was “Indifferent.”

**CONCLUSIONS:** Telephone-administered pharmacist intervention can improve BP control modifying patients’ beliefs and concerns about treatments, as well as involving patients as participants in the management of their health.

**PCV157 FACTORS ASSOCIATED WITH THE DURATION OF ANTICOAGULATION THERAPY FOLLOWING ACUTE VTE IN ENGLAND IN GENERAL PRACTICE: AN OBSERVATIONAL STUDY USING CPRD-HES DATABASES**

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**BACKGROUND:** Current guidelines recommend a minimum of 3 months’ anticoagulation (AC) following venous thromboembolism (VTE). The decision to prolong treatment depends on clinicians’ perception of benefit-risk, patient characteristics, and adherence to evidence. As evidence is typically performed in a controlled setting, variable reliability is important to consider in routine care. **OBJECTIVES:** To describe the duration of AC following VTE in clinical practice in England and identify factors associated with longer duration. **METHODS:** Retrospective study of all VTE events between 1 April 2008 and 31 March 2012 in linked Clinical Practice Research Datalink/Hospital Episode Statistics databases. We defined VTEs by Read or ICD-10 codes with anticoagulant prescription within 45 days after VTE or hospital discharge. We used multivariate Cox regression to identify factors associated with AC duration (event–end of AC).

**RESULTS:** Of 113,353 VTEs, 45.0% were females and 47.8% were men. Mean patient age was 69.3 years. Median AC duration was 219 days. In the Cox model, previous VTE was strongly associated with increased AC duration (HR 0.46 [95%CI 0.42–0.50]). Other factors associated with longer AC duration were age >65 yr (HR 0.41, 95%CI 0.39–0.43), female gender (HR 0.60, 95%CI 0.58–0.63), and comorbidity (HR 1.22, 95%CI 1.19–1.25).

**CONCLUSIONS:** In recent practice in England, most patients received more than 6 months of AC therapy after VTE. Factors associated with prolonged AC duration were age >65 yr, female gender, and comorbidity. However, these factors were not significant differences between IG and IG and for both Necessity and Concern score (t=5.74, p<0.001; t=7.86, p<0.001 respectively). Patients were divided into four attitudinal groups based on their BMQ results and data showed that t12 88.3% of IG patients were “Accepting” and 15.5% were “Indifferent.” None “Skeptic” patients were found in the IG and only 1.2% was “Indifferent.”

**CONCLUSIONS:** Telephone-administered pharmacist intervention can improve BP control modifying patients’ beliefs and concerns about treatments, as well as involving patients as participants in the management of their health.