aggressive payer policies encouraging VKA prescribing are expected across the EU, together with extended pricing and reimbursement negotiations following each NOAC label expansion, in order to manage healthcare budgets.

**PCV153**

REAL-WORLD IDENTIFICATION OF EUROPEAN PATIENTS WITH STATIN-ASSOCIATED SYMPTOMS: CLINICAL PRACTICE COMPARED WITH CLINICAL GUIDELINES

Hovingh GK1,2, Gandra SR3, McKendrick J1, Dent R4, Wifieff HM4, Catapano AL2, Oh P5, Rosenson RS6, Strokes E3

1Academic Medical Center, Amsterdam, The Netherlands, 2Amgen, Inc., Thousand Oaks, CA, USA, 3PRMA Consulting, Hampshire, UK, 4PRMA Consulting, Fleet, UK, 5University of Milan, Milan, Italy, 6Toronto Rehabilitation Institute, Toronto, ON, Canada, 7Mount Sinai School of Medicine, New York, NY, USA.

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 2014. 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 (EASC/PS) 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 of 65% (RAC 59–71%) reported being able to diagnose MRS in patients receiving a statin, whereas MRS resolved, and an average of 38% (RAC 32–45%) reported using a combination with the same statin to confirm whether MRS were SAS. Of those who did not rechallenge were broadly consistent with the current clinical consensus in Europe.

Most clinicians (average 74%; RAC 63–85%) reported rechallenging patients with a similar statin to confirm whether MRS were SAS. Across countries, an average of 69% of clinicians reported testing for elevated creatine kinase (CK) levels in patients who were unable to tolerate statins at the label-recommended dose, a commonly recommended test for statins. A web-based survey was conducted in France, Germany, Italy, the Netherlands, Poland, Spain, Sweden, and the UK in February–March 2014. 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 (EASC/PS) to explore their alignment. METHODS: A web-based survey was conducted in France, Germany, Italy, the Netherlands, Poland, Spain, Sweden, and the UK in February–March 2014. 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 (EASC/PS) 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 of 65% (RAC 59–71%) reported being able to diagnose MRS in patients receiving a statin, whereas MRS resolved, and an average of 38% (RAC 32–45%) reported using a combination with the same statin to confirm whether MRS were SAS. Of those who did not rechallenge with the same statin (61% (RAC 57–73%) reported rechallenging patients with the same statin to confirm whether MRS were SAS. Of those who did not rechallenge (39%) found that MRS resolved, and an average of 38% (RAC 32–45%) reported using a combination of rechallenging, 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 EASC/PS, 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?

Hovingh GK1, Gandra SR1, McKendrick J1, Dent R4, Wifieff HM4, Catapano AL2, Oh P5, Rosenson RS6, Strokes E3

1Academic Medical Center, Amsterdam, The Netherlands, 2Amgen, Inc., Thousand Oaks, CA, USA, 3PRMA Consulting, Hampshire, UK, 4PRMA Consulting, Fleet, UK, 5University of Milan, Milan, Italy, 6Toronto Rehabilitation Institute, Toronto, ON, Canada, 7Mount Sinai School of Medicine, New York, NY, USA.

OBJECTIVES: To compare the management of statin-treated patients with hypercholesterolemia and statin-associated symptoms (SAS) in real-world practice across eight European countries with the latest European Atherosclerosis Society Consensus Panel Statement (EASC/PS) and decisions of national health technology assessment (HTA) agencies. METHODS: A web-based survey was performed in six European countries: France, Germany, Italy, the Netherlands, Poland, Spain, Sweden, and the UK in February–March 2014. Sixty clinicians (specialists and general/family physicians, 2:1 ratio per country) answered questions about the management of patients with SAS. Targeted literature searches, followed by a telephone survey, were used to identify HTA data before and after the survey for comparison with survey outcomes. RESULTS: Overall, 319 clinicians (76% cardiologists) completed the survey. An average of 58% of clinicians (range across countries 40–65%) reported using a lower dose of statin in patients who were unable to tolerate statins at the label-recommended dose, a practice which is recommended by the EASC/PS. On average, 52% of patients known to have SAS continued to receive a low-dose statin, usually with other lipid-lowering therapies (LLTs). Of the remaining 48%, 37% received alternative LLT only and an average of 11% of patients with SAS received no statin or alternative LLT. Ezetimibe was the most common first choice of non-statin LLT for patients with SAS, either without concomitant statins (average across countries 74% clinicians) or in combination with a low-dose statin as recommended by the EASC/PS (average across countries 79% clinicians). Ezetimibe is recommended by most national and regional HTA agencies in the surveyed countries. A meta-analysis of comparative studies on statins, SASS, and RAC concerned the limitations of the supporting evidence. CONCLUSIONS: This survey identified potential treatment gaps in the management of patients with SAS: in some cases patients receive no LLT, leaving them without treatment for hypercholesterolemia.

**PCV155**

EFFECTIVENESS OF THE ST2 FOR PROGNOSIS IN HEART FAILURE: SYSTEMATIC REVIEW AND META-ANALYSIS

Kim SY1, Bang HY2, Sul AR3

1National Evidence-based Collaborating Agency, Seoul, South Korea

OBJECTIVES: ST2 reflects activity of the cardioprotective signal and it is a prognostic marker in heart failure (HF). The ST2 test is one of the tests used to determine the effectiveness of the ST2 for determination of the prognosis of patient with heart failure. METHODS: We searched the 8 Korean databases and overseas databases including Ovid-MEDLINE, Ovid-EMBASE and Cochrane Library. Total 365 studies were searched and 19 studies and extracted data of were included in the final assessment. Each of the stages from literature search and extraction of data were carried out independently by 2 researchers. We used tools of Scottish Intercollegiate Guidelines Network (SIGN) to determine the quality of the evidence. RESULTS: The effectiveness of the ST2 was assessed by means of association with prognosis/risk ratio (RR) or odds ratio (OR), accuracy of forecasting of the prognosis, stratification of risk, correlation with the comparative test and relevance with clinical symptoms. The results from the ST2 was 1.01–4.54. The ST2 ratio was 1.054–2.4. On the other hand, RR of hospitalization of BNP was 1.15–2.0, the RR or OR of death arising from NT pro-BNP was 0.19–1.24. The sensitivity/specificity of the ST2 in patients with CVD and AUC values were 0.97/0.74. CONCLUSIONS: The effectiveness of (Risk Reclassification Improvement, NRI) on the death rate were reported to be significant at 9.4 and 9.9 in the 2 studies, but 1 study reported that stratification of risk of the death rate was 0.049 and stratification of risk of hospitalization rate was 0.006. There were no correlation. The efficiency of BNP with NT pro-BNP was 0.28–0.523. The correlation coefficient with the peak VO2was 0.30 and with 6-minute walk distance was 0.22. CONCLUSIONS: The ST2 is effective in determining the prognosis of patients with heart failure.

**PCV157**

THE EFFECT OF A TELEPHONE COUNSELING INTERVENTION BY PHARMACIST ON PATIENTS’ BELIEFS ABOUT MEDICINES AND BLOOD PRESSURE CONTROL

Daniah Scala D1, Caruso Domenico D1, D`avinio Maria M2, valeria Marina Monetti V2, Valentina Orlando V2, Francesca Guerriero F2, Enrica Menditte F2

1AORN Cardarelli, Naples, Italy, 2University of Naples Federico II, Naples, Italy

OBJECTIVES: Pharmacists, working as part of the multidisciplinary team, have a relevant role in improving clinical outcomes through providing educational intervention, medicine management intervention, or a combination of both. The purpose of this study was to determine if a telephone counseling intervention administered bi-monthly by pharmacist on patients’ beliefs about antihypertensive medicines and blood pressure control. METHODS: Subjects were selected on a total of 36 subjects and recruited to their attending physicians. Patients were divided into two groups: the intervention group for telephone counseling intervention and the control group (CG). Patients were recruited from the outpatient unit through the University Department on Hypertension and Therapy. And the Phonopharmacist Counseling. The intervention group had interested counseling intervention. The control group had usual care. RESULTS: A total of 164 patients (80 in the control group, CG, and 84 in the intervention group, IG) were recruited. At the end of follow-up, the reduction in SBP and DBP was significant in IG (p<0.001) and there were also significant differences between IG and CG 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 at 12 83.3% of IG patients were “Accepting” and 15.5% were “Refusing”. None “Skeptical” patients were found in the IG. Only 1.2% was “Ambivalent”. None “Skeptical” patients were found in the IG and only 1.2% was “Indifferent”. CONCLUSIONS: Telephone-administered pharmacist intervention can improve BP controlling patients beliefs and concerns about treatments, as well as involving patients as participants in the management of their health.