in 38% of ischemic stroke patients (46% in Germany vs 22% in Spain). **CONCLUSIONS:** These data are showing that statins are widely used in the acute setting with significant differences across Europe.

PCV113

PATIENTS WITH ACUTE ST-ELEVATION MYOCARDIAL INFARCTION: WHO ARE THE "UNTREATED PATIENTS" IN HOSPITALS WITH CATH LAB?

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OBJECTIVES: STEMI patients (pts) presenting <12 h since onset of symptoms should receive reperfusion therapy, which results in important mortality reduction. However, critical presentation timing is not the only factor that influences treatment choice for STEMI pts. In this study we assess the scale at which clinical guidelines are followed in the treatment of STEMI patients presenting within the timeframe of reperfusion therapy. **METHODS:** This was a retrospective patient diary study using the IMS Health Acute Cardiovascular Analyzer. The study was conducted in 264 hospitals with Cath-Lab facilities in France, Germany, Italy, Spain and UK. They treated a total of 2553 patients diagnosed with STEMI, during the period of August 2006 and April 2007, with a mean of 10 patients per hospital. Hospitals were selected to be representative by geographic regions, size and facilities in each country. We analysed the data to determine factors associated with patients not receiving reperfusion therapy. **RESULTS:** We found 2333 (91%) pts were admitted within 12 hours of onset of symptoms, where 49% had primary PCI, 16% received thrombolytics, 15% received thrombolytics and PCI, 8% had PCI outside the 12 hours reperfusion window, 9% didn't receive PCI neither thrombolytics, 2% had CABG: We report data from 393 patients who didn't receive reperfusion therapy and accounts for patients not receiving primary PCI or thrombolytics: 66% had dyslipidaemia, 63% hypertension, 37% CHF, 30% diabetes, 19% age >80, 12% stable angina and 11% with PAD. Also, it was noted that 40% of these patients experienced delay in-hospital diagnosis, and thus haven't received reperfusion therapy within the 12 hours window, 10% were contraindicated to thrombolytics, and 39% were scheduled to receive revascularisation. In-hospital mortality accounted for 14% of the total untreated population. **CONCLUSION:** This study concludes that 17% of STEMI patients admitted to Cath Lab hospitals within 12 hours of onset of symptoms in Europe don't receive reperfusion therapy even when catheralization facilities are available.

PCV114

SEARCHING THE OPTIMAL TREATMENT MIX STRATEGY WITH A TREATMENT MIX CHART APPROACH—THE CASE OF CHOLESTEROL LOWERING IN SWEDEN

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OBJECTIVES: Different statin dose titration and treatment switching strategies of atorvastatin, rosuvastatin, and simvastatin were compared in the Swedish setting. The objective was to find the optimal treatment mix strategy (i.e. a mix that provides the greatest benefits in terms of cost (€ in 2008 value) per patient treated to target (PTT)) in high-risk patients with elevated LDL-cholesterol (LDL-C). **METHODS:** A decision-analytic model with Monte Carlo simulation was developed to estimate the expected net benefits of different statin treatment mix strategies. Since it has been demonstrated that the optimal option may not always have the highest probability of being cost-effective for a given value of cost-effectiveness threshold (λ), a new approach, named the optimal treatment mix chart (OTMC), was developed. The OTMC is based on cost-effectiveness acceptability frontiers (CEAF). **RESULTS:** In the base case (LDL-C = 4.42 mmol/l) and when $\lambda < €350$/PTT, the optimal option was to initiate treatment with simvastatin 10 mg and to titrate dose up to the assumed maximum tolerated dose (40 mg) until the treatment target (LDL-C ≤ 2.5 mmol/l) was reached. When $€350 < \lambda < €775$, the optimal option was to initiate a treatment mix, where simvastatin was up-titrated to 40 mg and then switched to a higher-potency statin (here rosuvastatin), when needed. When $\lambda > 775€$ the optimal option was to initiate a treatment with simvastatin 20 mg and then directly switch to rosuvastatin, when needed. **CONCLUSIONS:** The selection of the optimum treatment mix is conditional on baseline assumptions. OTMC provides a natural and practical graphic tool for presenting the optimal treatment mix at different λ-values under different baseline assumptions (e.g. different baseline LDL-C levels). The majority of Swedish patients will, currently and in real-life, not generally experience dose titration and/or change of statin after treatment initiation. Therefore, rosuvastatin has a central role in a treatment "mix" for high risk patients with the LDL-C exceeding 4.2 mmol/l.

PCV115

ASSESSING THE POTENTIAL BENEFITS OF CHANGING REIMBURSEMENT CRITERIA FOR LIPID LOWERING THERAPY IN KOREA

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OBJECTIVES: To contain health care expenditure, the Korean National Health Insurance (NHI) sets reimbursement criteria for lipid-lowering therapy that are quite strict. We assessed the potential health and economic effects of relaxing the criteria for lipid-lowering treatment in Korea to align with NCEP-ATPIII recommendations. **METHODS:** A microsimulation Markov model was constructed with yearly cycles and the health states 'Alive without cardiovascular disease (CVD)', 'Alive with CVD', 'Dead from CVD' and 'Dead from non-CVD causes'. It was populated with CVD-naïve subjects aged ≥55 years from the nationally-representative 2005 Korean NHANES. Follow-up until death or age 99 years was simulated. An Asian-specific risk equation (Wu 2006) was applied to estimate cardiovascular risks. Sex-and-age-specific mortality risks were drawn from national health statistics. Decision analysis compared treatment according to the two sets of criteria. Eligible patients were all prescribed atorvastatin, the lipid-modifying efficacy and costs of which were drawn from a meta-analysis and current drug pricing schedules, respectively. CVD cost estimates were provided by the Korean Health Insurance Review and Assessment Services. A five percent annual discount rate was applied. **RESULTS:** Nearly three times more Koreans aged ≥55 years would quality for lipid-lowering therapy if NCEP-ATPIII instead of NHI criteria were to be applied (43.1% vs 15.0%). Compared to treatment under NHI criteria, the treatment of 1000 Koreans aged ≥55 years under NCEP-ATPIII criteria would lead to 38 less cardiovascular events (447 vs 409) and 3195 more QALYs (10,843 vs 7648) over a lifetime. There would be saving of 845 million KW in net costs (9876 vs 10,721 million). **CONCLUSIONS:** Current criteria for lipid-lowering therapy in Korea are conservative. If NCEP-ATPIII criteria were to be adopted, as in many other countries, significantly more patients would qualify for treatment, but the strategy would represent a more effective and cost-effective way of preventing CVD.