A total of 3173 dyslipidemic patients treated with LLA and managed by general practitioners were randomly selected from a French GPs computerized database. History of CHD and number of CRF (age, family history of premature CHD, smoking, hypertension, HDL-C < 0.9mmol/L, diabetes) were documented. Percent of patients above AFSSAPS TIL and NCEP goal was defined for each level of CHD risk. RESULTS: Twenty-one percent of patients had a history of CHD. Using AFSSAPS guidelines the distribution of primary prevention patients according to the number of CRFs (1, 2, 3, >3) was 1.6, 25.5, 31.7, and 20.1%, respectively. Almost 40% of CHD patients remained above TIL and the percentages of primary prevention patients above TIL varied from 3.9% for patients with 1 CRF to 46.5% for patients with >3 CRFs (p < 0.001). Using NCEP guidelines, percentage of patients not at goal in the different CHD risk categories were significantly higher and 74.3% of CHD patients were not at LDL-C treatment goal. CONCLUSION: Seventy-three percent of patients prescribed LLA were at high CHD risk. Increasing with CHD risk level, large numbers of patients were above TIL and LDL-C treatment goal. More effective interventions are needed in lipid lowering therapy. * AFSSAPS: French Drug Agency.

PCV8

WARFARIN ANTICOAGULATION AND OUTCOMES IN ATRIAL FIBRILLATION PATIENTS: A SYSTEMATIC REVIEW AND META-ANALYSIS

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OBJECTIVES: To examine the relationship between International Normalized Ratio (INR) and outcomes (major bleeding events and strokes) in atrial fibrillation (AF) patients on anticoagulation with warfarin. METHODS: A systematic review and meta-analysis of studies published in English between January 1, 1985 and October 30, 2002 was performed. MEDLINE (PubMed), Current Contents, and relevant reference lists were searched. Studies enrolling patients with nonvalvular AF on warfarin anticoagulation were eligible for inclusion if they reported stroke and/or major bleeding events in relation to INR, or time spent in therapeutic range. The risk of bleeds in anticoagulated patients (INR > 3) and the risk of strokes in underanticoagulated patients (INR < 2) was assessed. RESULTS: Twenty-one studies (6,248 patients) met all inclusion criteria. Of the 21 studies, target conventional INR of 2 to 3 was used in 9. An INR < 2, compared with an INR > 2, was associated with an odds ratio (OR) for ischemic events of 5.07 (95% confidence interval (CI) = 2.92, 8.80). An INR > 3, compared with an INR < 3, was associated with an OR for bleeding events of 3.21 (95% CI = 1.24, 8.28). On average, in the four studies with a target INR range of 2 to 3, AF patients on warfarin spent 61% of time within, 13% of time above and 26% below the therapeutic range. CONCLUSION: Available evidence indicates that in patients with non-valvular AF, the risk of ischemic stroke with insufficient warfarin anticoagulation (INR < 2), and the risk of bleeding events with overanticoagulation (INR > 3) is significantly higher relative to AF patients maintained within the recommended INR of 2 to 3. However, the data are sparse, heterogeneous, and mostly based on clinical trials. More studies evaluating clinical outcomes in relation to INR are needed, especially in a real-world setting.

PCV9

LIPID MANAGEMENT AND FACTORS AFFECTING GOAL ATTAINMENT IN LATIN AMERICA

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OBJECTIVE: Evaluate treatment of hyperlipidemia in Latin America and determine factors associated with NCEP-III LDL-C goal attainment in Coronary Heart Disease (CHD)/CHD risk equivalent (< = 100mg/dl) and non-CHD patients with 2+ risk factor (< = 130mg/dl). METHODS: Retrospective observational study at 40 randomly selected specialists and 20 general practices (GP) centers in Mexico, Brazil and Colombia. Physicians randomly selected adult (age > 18) patients prescribed lipid lowering drug (LLD) for minimum 12 weeks. Date of first LLD was the index date; follow-up cholesterol measures and LLD prescribed were evaluated for minimum 3 months after index date. RESULTS: Three-hundred sixty patients were studied, 25% from GP and 75% from specialist centers; 45% had CHD/CHD equivalent, and 35% had 2+ risk factors. Mean age was 57 yrs (SD 12) and 53% were male. Median LDL-C reduction required to attain NCEP-III goal at baseline was 48% for CHD and 23% for non-CHD patients. There was no significant difference in LDL-C reduction required at baseline among the three countries. Initial LLD for CHD group were 27% low dose statins (simvastatin 10mg or equipotent), 36% medium dose statins (simvastatin 20mg or equipotent) and 18% high dose statins (simvastatin 40mg or equipotent). Proportion of physicians prescribing high dose statins was higher (p < 0.05) in Brazil (26%) than Mexico (16%) and Colombia (15%). Overall 45% patients treated with statins alone attained LDL-C goals; only 28% of CHD group. After controlling for age, gender, country, initial LLD, titration and comorbidities, patients with baseline LDL-C > = 190mg/dl (OR = 0.47; 95% CI 0.30--0.74), hypertension (OR = 0.58; 95% CI 0.37--0.92) and CHD (OR = 0.38; 95% CI 0.24--0.60) were least likely to achieve LDL-C goal. CONCLUSION: Hyperlipidemic patients in some Latin-American countries are generally treated with statins alone; majority (55%) of patients failed to reach recommended NCEP-III LDL-C goals.

PCV10

THE IMPACT OF ADEQUATE MONITORING OF LIPID LEVELS IN PATIENTS HAVING ELECTIVE PERCUTANEOUS CORONARY INTERVENTIONS IN A LOCAL PUBLIC HOSPITAL IN HONG KONG

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OBJECTIVES: Clinical trials demonstrated that low-density lipoprotein (LDL) lowering therapy reduces mortality and morbidity in coronary heart disease patients. Therefore, it is important to ensure patient adhering to their LDL-lowering therapies. In July 2001, an intensive treatment protocol was introduced at the United Christian Hospital (UCH) in Hong Kong. The purpose of this study is to describe the impact of the protocol on the lipid levels in patients having elective percutaneous coronary interventions (PCI). METHODS: Case notes were reviewed retrospectively. The study cohort consisted of patients who were above 18 years old requiring first elective PCI from 1 July 2000 to 30 June 2002. Patients with a history of previous PCI or coronary artery bypass surgery were excluded. The intensive