to apixaban. One-way and probabilistic sensitivity analyses indicated that model conclusions were robust across a wide range of inputs. CONCLUSIONS: Apixaban appears to be a dominant alternative to LMWH/exdaban for the treatment and prevention of VTE.

**PCV14**

REAL-WORLD EFFECTIVENESS OF AMLODIPINE/VALSARTAN/ HYDROKLOROTHIAZIDE SINGLE-PILL COMBINATION IN THE TREATMENT OF PATIENTS WITH ESSENTIAL HYPERTENSION

Vitale D1, Antunes M2

1Novartis Farma – Produtos Farmacêuticos S.A., Porto Salvo, Portugal, 2Faculdade de Ciências da Universidade de Lisboa, Lisboa, Portugal

OBJECTIVES: Uncontrolled hypertension remains a major problem for health care systems worldwide, being strictly related to a persistently elevated burden of cardiovascuar mortality and morbidity. Because of the multifactorial nature of hypertension, the role of combination therapy to achieve blood pressure (BP) control. This analysis aimed to further investigate the effectiveness of amlopidine/valsartan/hydroklothiazide (A+V+H) single-pill combination in lowering the BP of hypertensive patients, previous assessed in an observational study. METHODS: This was a real-world, observational study conducted in 7132 patients diagnosed with essential hypertension and for whom treatment with A+V+H was indicated according to clinical practice. The observational period was 3 months. Descriptive analysis, hypothesis testing and linear regression models were performed. RESULTS: The reduction in systolic blood pressure (RSP) between baseline and last visit was 11.34±10.63 mmHg (mean±SD). A t-test showed that both reductions are statistically significant. CONCLUSIONS: The combination of amlopidine/valsartan/hydroklothiazide (A+V+H) was cost-effective and safe in real-world patients. Further randomized controlled trials are needed to confirm these findings.

**PCV15**

A MIXED-TREATMENT COMPARISON (MTC) TO COMPARE THE EFFICACY OF ANTI-PLATELET AGENTS IN TREATMENT AND SECONDARY PREVENTION OF VENOUS THROMBOEMBOLISM (VTE) IN PATIENTS WITH DEEP VEIN THROMBOSIS (DVT)

Edwards SJ, van Velthoven MH, Crawford F

BM: Lancet ONK

OBJECTIVES: New oral anticoagulants (NOACs) are available for the treatment and prevention of VTE, but evidence on their clinical effectiveness compared with existing treatments is limited. We compared the clinical effectiveness of edoxaban, dagabrant and rivaroxaban using adjusted standard dose warfarin (warfarin) as a common comparator in patients with DVT. This research was conducted during a review of the company’s submission (CS) to the National Institute for Health and Care Excellence (NICE) Single Technology Appraisal programme for the oral direct factor Xa inhibitor, edoxaban. METHODS: Randomised controlled trials (RCTs) for inclusion were identified using the CS for edoxaban (as part of Technology Appraisal [TA] 660). We assessed RCTs for comparability based on patient population, disease severity, and treatments received. We conducted a Bayesian MTC and explored fixed and random effects models. Odds ratio (OR) was the summary statistic for VTE recurrence and major bleed. RESULTS: The network of RCTs formed a “radiating star”. The Deviance Information Criterion (DIC) and the residual deviance with the number of unconstrained data points for both outcomes showed fixed and random effects models were an equally good fit. Due to the small number of studies and the shape of the network, the results from the fixed effects model are presented. Compared to warfarin were (OR=1 favours warfarin): VTE recurrence edoxaban OR 0.95 (95% Credible Interval [95% CI]: 0.62–1.40), dagabrant OR 1.27 (95% CI: 0.78–1.97), rivaroxaban OR 0.64 (95%CI: 0.40–0.96), major bleed edoxaban OR 0.84 (95% CI: 0.48–1.35), dagabrant OR 0.83 (95%CI: 0.50–1.31), rivaroxaban OR 0.92 (95% CI: 0.53–1.60). CONCLUSIONS: Rivaroxaban demonstrated a 36% reduction in risk of VTE recurrence compared to warfarin that was statistically significant at the 5% level. We did not identify other significant differences either when comparing NOACs to warfarin or when comparing NOACs with each other.

**PCV16**

COMPARATIVE EFFECTIVENESS OF TICAGRELOR VS. PRASUGREL IN PATIENTS WITH ACUTE CORONARY SYNDROME (ACS)

Kim K, Lee TA, Araki AK, Daido NM, Mietzsch RM, Touchette D, Walton SM

University of Illinois at Chicago, Chicago, IL, USA

OBJECTIVES: Randomized controlled trials have provided evidence that both prasugrel and ticagrelor reduce complications in patients with acute coronary syndrome (ACS). However, no head-to-head comparisons were performed between these third-generation drugs. The aim of this study was to compare the hospital administrative rates between patients receiving ticagrelor and prasugrel, with particular focus on percutaneous coronary intervention (PCI). METHODS: A Retrospective cohort study was designed to compare all cause hospitalization over 365 days post PCI discharge. Patients who received PCI with an ACS hospitalization between January 2012 and December 2013 were extracted from the MarketScan Research Hub Analytics MarketScan database. Eligible patients filled either a prasugrel or ticagrelor prescription within 14 days from the discharge date. To be included in the analytic cohort, patients needed to be continuously enrolled in the data up to six months prior to the index admission, and concomitant conditions that over period were assessed using Chi-square and Student t- tests for categorical and continuous variables, respectively. The effectiveness of ticagrelor vs. prasugrel was estimated using Cox proportional hazard model. RESULTS: A total of 9698 patients received PCI with a primary diagnosis of ACS (ST-segment elevated myocardial infarction [STEMI] or non-ST-segment elevated myocardial infarction [NSTEMI]) and ticagrelor or prasugrel were prescribed. Ticagrelor group was older and more likely to have a diagnosis of intracranial hemorrhage, cerebrovascular accident, cardiac disorders and renal disorders than the prasugrel group. The adjusted hazard ratio (HR) of ticagrelor vs. prasugrel was 1.056 (95% CI: 0.867, 1.285) which was unchanged after adjusting for the potential confounders (HR: 1.056 [95% CI: 0.867 – 1.280]). CONCLUSIONS: The selection of third-generation antiplatelet agents following PCI was not associated with a clinically or statistically significant reduction in hospital readmission.