VTE-related hospitalizations but the results were not statistically significant (odds ratio: 0.857; 95% CI: 0.596-1.233). Sensitivity analysis results agreed with the primary findings (odds ratio: 0.831; 95% CI: 0.622-1.100). CONCLUSIONS: The risk of hospitalization for VTE was found to be similar for users of typical and atypical anticonvulsant medication in this elderly Medicare population.

PCV4
TREATMENT PATTERNS, CLINICAL AND ECONOMIC BURDEN OF VENOUS THROMBOEMBOLISM IN ABDOMINAL SURGERY PATIENTS
Wang L, Duyinger AH, Du J, Xie L, Baser O
STATinMED Research, Ann Arbor, MI, USA

OBJECTIVES: To examine prophylaxis use as it relates to the clinical and economic burden of venous thromboembolism (VTE) in abdominal surgery patients. METHODS: A retrospective study (January 1, 2005 to December 31, 2007) was conducted using a subset of the MarketScan Hospital Drug Database and its linked outpatient MarketScan Commercial and Medicare Supplement databases. Patients’ demographics, clinical and discharge statuses were compared using Chi-square testing and standardized difference. Risk-adjusted healthcare visits and costs were estimated using the General Linear Model. Potential risk factors for VTE events were selected using the Cox Proportional Hazard Regression Model. RESULTS: In patients who underwent abdominal surgery (n=49,355), 24,473 (49.59%) received anticoagulant therapy during their hospitalization and until 30 days after discharge. VTE events for patients who received anticoagulant prophylaxis were 4.63% versus 7.06% for patients who did not receive anticoagulant prophylaxis. Compared with patients without VTE in the 6-month follow-up period, patients with VTE were more likely to be older, have comorbid conditions including previous VTE, major and minor bleeding, and cancer, and to have higher baseline health care visits and costs. After risk adjustment for pre-specified covariates, inpatient costs ($16,677 vs. $10,774), outpatient costs ($15,426 vs. $7,474), pharmacy costs ($2,541 vs. $1,862), and readmission rates (0.23% vs. 0.12%) were higher in patients who had VTE. In the multivariate analysis, appropriate anticoagulant prophylaxis was significantly associated with the reduced risk of VTE (HR: 0.510). CONCLUSIONS: The VTE event rate was lower for patients who received prophylaxis compared with those who did not. Since the healthcare costs of patients with an event were significantly higher than those of patients without an event, prophylaxis use is associated with lower health care costs.

PCV5
PREVALENCE, INCIDENCE, AND OUTCOMES OF CRITICAL LIMB ISCHEMIA IN THE MEDICARE POPULATION IN THE UNITED STATES
Baser O1, Verpilliat P1, Wang L1
STATinMED Research, Ann Arbor, MI, USA, Sanofi-Aventis Group, Paris, France

Critical limb ischemia (CLI) is a severe obstruction of the arteries that seriously decreases blood flow to the extremities resulting in amputation of the affected limb if left untreated. Despite the severity of the disease, there is a lack of data on prevalence, incidence and outcomes of CLI in the United States. OBJECTIVES: We conducted a large population-based study to directly estimate prevalence, incidence and outcomes of CLI in the United States. METHODS: Data from January 2006 to December 2008 were extracted from the U.S. Medicare database. We estimated 1) age, gender, race and diabetes-specific CLI prevalence and incidence rates using the direct standardization method, and 2) factors associated with CLI outcomes (eg revascularization, non-traumatic amputation, and mortality) among the CLI population, using the Cox proportional hazard regression model. RESULTS: A total of 68,074 patients were identified with eligible CLI ICD-9 codes in 2007 of whom 13,211 were diagnosed. Analyzing 2 years of data, CLI prevalence and incidence rates in this elderly population were 0.23% (0.28% for male and 0.20% for female patients) and 0.20% (0.23% and 0.17%), respectively. Just as with prevalence, incidence increased sharply among beneficiaries aged 65-69 (0.13%) to ≥85 (0.31%), was around 2.3 times higher in black patients compared to white patients, and 8.6 times higher in diabetic patients compared to non-diabetic patients. The overall incidence rates of leg revascularization and non-traumatic amputation in the year after CLI diagnosis were 29.7% and 25.2%, respectively. Compared to revascularization, patients who are older, male, black, and have diabetes had a higher risk of amputation. 30.3% of the patients died within the first year after CLI diagnosis. CONCLUSIONS: This first U.S. nationwide-based study shows that prevalence, incidence and outcomes are different according to patients’ socio-demographic characteristics and comorbidities, suggesting that CLI patient management varies among the U.S. population.

PCV6
ANALYSIS OF MYOCARDIAL INFARCTION RELATED CLINICAL OUTCOMES, HEALTH CARE UTILIZATION AND COSTS OF PATIENTS WITH NON-VALVULAR ATRIAL FIBRILLATION
Wang L, Xie L, Baser O
STATinMED Research, Ann Arbor, MI, USA

OBJECTIVES: To estimate clinical outcomes, healthcare utilization and cost burden of patients who suffered a myocardial infarction during the 180 days after diagnosis of non-valvular atrial fibrillation (NVAF) and compare it with patients who did not suffer a myocardial infarction. METHODS: Based on 2005-2007 U.S. Medicare advantage insurance claim files, patients aged 65 years and older who have had two or more primary diagnoses for NVAF occurring within 30 days of one another were selected. The 180-day follow-up event rates, healthcare facility use and costs for patients with a myocardial infarction and those without were compared. Risk adjustment was performed using the propensity score matching method with the PropChoice™ algorithm. RESULTS: In patients who were identified with NVAF (n=18,573), 258 (1.39%) suffered a myocardial infarction during the 180 days after NVAF diagnosis. Patients were not significantly different in terms of gender, region, and baseline comorbid conditions. After risk-adjustment for pre-specified covariates, mortality (10.08% vs. 3.93%; p<0.0001), outpatient emergency room (ER) visits (82.56% vs. 48.06%; p<0.0001), acute coronary syndrome (63% vs. 2/100 person years), ischemic stroke (31% vs. 4/100 person years), major bleeding (6% years) and non-major clinical relevant bleeding (24% vs. 6/100 person years) were all higher for patients who suffered a myocardial infarction compared to those who did not. Besides inpatient costs ($26,646 vs. $9,393), risk-adjusted outpatient ER costs ($1,716 vs. $863) were also higher for myocardial infarction patients. The risk-adjusted differences in healthcare costs were significant ($16,564 vs. $10,366; p<0.0001). CONCLUSIONS: Most of the adverse events analyzed were higher for patients who suffered a myocardial infarction after NVAF relative to patients who did not. Total health care utilization and costs were also significantly increased.

PCV7
ANALYSIS OF TREATMENT PATTERNS AND COSTS FOR VENOUS THROMBOEMBOLISM, MAJOR AND MINOR BLEEDING EVENTS IN HOSPITALIZED MEDICALLY-ILL PATIENTS
Baser O, Xie L, Du J, Wang L
STATinMED Research, Ann Arbor, MI, USA

OBJECTIVES: To examine prophylaxis use, incidence of VTE, major bleeding, minor bleeding and associated economic burden over 90 days in hospitalized medically-ill patients. METHODS: A retrospective study (January 1, 2005 to December 31, 2007) was conducted using a subset of the MarketScan Hospital Drug Database and its linked outpatient files from the Market Scan Commercial and Medicare Supplement databases. Details were extracted on combination therapies within the VA population. CONCLUSIONS: The risk of anticoagulant prophylaxis, patients who received anticoagulant prophylaxis had significantly lower VTE events (1.47% vs. 3.58%, p<0.0001). Although there was no significant difference in rates of major bleeding and minor bleeding, after risk-adjustment for pre-specified covariates, patients with outcome events were significantly associated with higher total health care costs (VTE: $40,523 vs. $17,698 p<0.0001; Major bleeding: $27,430 vs. $18,137 p<0.0001; Minor bleeding: $25,696 vs. $17,410 p<0.0001). CONCLUSIONS: Despite existing guidelines, few medically-ill patients are receiving anticoagulant prophylaxis. Appropriate anticoagulant prophylaxis use results in lower VTE event rates and total follow-up health care costs in hospitalized medically-ill patients.

PCV8
EVALUATION OF A SAFETY INITIATIVE AND OUTCOMES FOR PATIENTS ON STATIN-FIBRATE COMBINATION THERAPIES IN THE VETERANS AFFAIRS POPULATION
Yi, Tran JN, Bounhavong M
Veterans Affairs San Diego Healthcare System, San Diego, CA, USA

OBJECTIVES: To identify the reported higher incidences of adverse events in patients on combination statins and fibrates compared to statins alone, the Veterans Affairs (VA) San Diego initiated an intervention to reduce the number of patients on combination therapies. This study aimed to evaluate the effectiveness and safety of statin-fibrate combination therapies within the VA population. METHODS: This was a retrospective cohort study of VA medical, pharmacy, and laboratory data. Patients on a statin and fibrate combination in June 2008 were selected and stratified based on continuation or discontinuation of combination therapy by June 2009. Hyperlipidemic measures, safety measures, and adverse events were obtained pre- and post-intervention. Chi-square and ANOVA tests were utilized to test between-group differences and paired t-tests were conducted to analyze within-group differences at pre- and post-intervention. Repeated measures regressions were used to assess longitudinal differences between groups over time. RESULTS: No differences in rates of cardiovascular disease were found between patients who continued and discontinued combination therapy at baseline and one year later. No incidences of rhombomylitis and pancreatitis were reported. Compared to those who continued combination therapy, those who discontinued combination therapy had significantly lower total cholesterol (184 versus 172 mg/dL, p=0.029), high density lipoprotein cholesterol (HDL) and triglycerides (27 versus 15 mg/dL, p<0.0001), and lower cardio-metabolic risk scores (p<0.0001). CONCLUSIONS: Discontinuation of statin-fibrate combination therapy did not have a significant impact on the management of hyperlipidemia measures and no differences in adverse events were observed. Further studies should be done to assess the long-term effects of statin-fibrate combination therapy.