ACCORDING TO GUIDELINES IN SPAIN
INFARCTION WITH ST SEGMENT ELEVATION (STEMI)
MANAGEMENT OF PATIENTS WITH ACUTE MYOCARDIAL
COMPARE QUALITY OF CARE: IS IT MEANINGFUL?

METHODS: The analysis utilized the Victorian Admitted Episodes Data Set from 1996–2005, which contains data on all patients admitted to acute private and public hospitals in the state of Victoria, Australia. A hazard model was used to model time to failure, which was defined either as 30-day mortality, or readmission for subsequent AMI. Hospitals were grouped into one of five types and these were included as explanatory variables. Other control variables, including AMI location, co-morbidities, treatments, and demographics, were added to the model one by one in order to determine their effect on survival, and on the effect of hospital type on survival. RESULTS: The impact and significance of hospital type on survival depended strongly on the definition of failure. Large teaching hospitals had significantly higher failure rates than all other hospital types when failure was defined as readmissions, while this ordering was almost reversed when failure was defined as 30-day mortality. Controlling for planned and unplanned treatments did not significantly affect these results. Including indices of socio-economic status amplified the effects when failure was defined as readmissions, but had no significant effect otherwise. Location of AMI was significant only when failure was defined as 30-day mortality, and improved the relative performance of large regional base and suburban hospitals. All other variables were generally similar in both models. CONCLUSION: The effect of hospital type on survival depended strongly on the definition of failure and somewhat on the inclusion of certain control variables. The results suggest that comparing the effects of hospital type using patient outcomes requires careful consideration.

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CENTRALISED PAN-EUROPEAN SURVEY ON THE UNDER-TREATMENT OF HYPERCHOLESTEROLEMIA IN PATIENTS USING LIPID LOWERING DRUGS (CEPHEUS)
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OBJECTIVES: Surveys evaluating plasma lipid goal attainment in CHD patients prior to the updated European guidelines on CVD prevention (Third Joint Task Force [TJTF]) showed that hypercholesterolemia is inadequately treated. Limited data accounts for the reasons behind this. The aim of this survey was to evaluate the current use and efficacy of lipid lowering drugs (LLD), and to identify possible patient/physician characteristics associated with failure to be at the TJTF guideline LDL-C target. METHODS: An European multi-centre, cross sectional survey in 8 countries including patients on LLD for >3 months (stable medication >6 weeks). One visit was scheduled for data collection including fasting lipids analysed by a central laboratory. In all but 1 country physicians and patients filled in a questionnaire about aspects of hypercholesterolemia and treatment. Data was analysed centrally. Determination of individual LDL-C targets followed 2003 TJTF guidelines including SCORE tables. RESULTS: A total of 15,199 patients were recruited (14478 included in the final analyses) with the following characteristics: mean (±SD) age 63.2 (11.3) yrs (45% females), waist circumference 97.0 (13.3) cm. 62% had a history of hypertension, 18% were smokers, 32% of the subjects had metabolic syndrome (MS) according to the NCEPATP III criteria. Reason to prescribe LLD: 67% primary prevention (PP), 33% secondary prevention (SP) or familial hypercholesterolemia. 93% of the patients used within 2 previous years. The guidelines of reference were the American College of Cardiology/American Heart Association (ACC/AHA 2004) and European Society of Cardiology (ESC 2003). Descriptive statistics and comparison of averages (“t” of Student and Or of Mann-Whitney) and proportions (Chi-squared) were realized with SAS package. RESULTS: A total of 1439 out of 1588 patients were valid for analysis (90.6%). A total of 80.3% were males, middle age were 62.4 years-old (STD = 11.8) and the average BMI was of 27.8 Kg/m2 (STD = 3.7). The most frequent concomitant diseases were hypertension (53.6%) and diabetes mellitus type II (28.5%). The average of time after STEMI was 9.6 months (STD = 7.2). The treatments more frequently used were statins (93.6%), aspirin (93.2%) and beta-blockers (83.5%). The treatments used in accordance with guidelines were antiaggregants/anticoagulants (99.7% in both guidelines), statins (94.4% in ACC/AHA and 93.5% in ESC) and beta-blockers (83.5% in both guidelines), staying in the second term ACE inhibitors/ARBs (78.2% ACC/AHA and 59.7% ESC) and aldosterone antagonists (19.3%); this one only recommended by the ACC/AHA. To summarize, 65.3% (ACC/AHA) and 52.4% (ESC) of the patients were being treated according guidelines. Regarding lifestyle factors, only 9.2% (ACC/AHA) and 6.4% of patients followed the overall guidelines’ recommendations. CONCLUSION: This study shows a low implementation of guidelines by Spanish physicians in managing patients with STEMI, with more adherences to ACC/AHA 2004 than ESC 2003 guidelines. Treatment recommendations are more followed than life-style recommendations. Based on this study, actions are needed to increase adherence of Guidelines in Spain.

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MANAGEMENT OF PATIENTS WITH ACUTE MYOCARDIAL INFARCTION WITH ST SEGMENT ELEVATION (STEMI) ACCORDING TO GUIDELINES IN SPAIN
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OBJECTIVES: To evaluate degree of implementation of the American and European guidelines related to the treatment as secondary prevention, in the management of patients with acute myocardial infarction with ST segment elevation (STEMI). METHODS: Cross-sectional and multicentric study realized in cardiology outpatient clinics in Spain. Physicians included consecutively outpatients over 18 years with STEMI happened 18–49 years were 57% less likely (OR 0.43 95% CI 0.41–0.46, p < 0.0001), to receive antilipemics than patients ≥65 years old. Patients with substantial disease burden (Charlson Index >1) were 9% more likely to receive antilipemics (OR 1.09, 95% CI 1.01–1.18, p = 0.024) than those with no or moderate disease burden (Charlson ≤1). CONCLUSION: Although CHD remains a leading cause of U.S. mortality irrespective of sex, race/ethnicity, or age, and antilipemics benefit patients across these demographic characteristics, we found that females, Blacks, and younger (aged 18–50 years) Medicaid patients with dyslipidemia were significantly less likely to receive antilipemics than their male, White or older counterparts.