ment rate of 90%) and B (drugs at reimbursement rate of 50%) were observed. **RESULTS:** In 2010, total expenditure for all prescription drugs was €36.5 million. In 2011, total expenditure for all prescription drugs was €43.2 million. Thus, there was a cost / consumption increase of 18.23% across the board. Cardiovascular therapeutic area carried most of the burden in 2010 and 2011 with the above average increase of 26.46% amounting to 31.44% of total consumption in 2011 **CONCLUSIONS:** Moderate increase in cost / consumption from 2010 to 2011 predominantly accounts for disease management medicines.

PCV120

THE FACTORS WHICH AFFECT THE PRICE OF ANTIHYPERTENSIVE COMBINATIONS INCLUDING ANGIOTENSIN RECEPTOR BLOCKERS

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OBJECTIVES: To define the factors which affect the price of single pill combinations of antihypertensive including angiotensin receptor blockers (ARB) in Turkey and to estimate the price of amlodipine / valsartan 10/320 mg combination (28 package). **METHODS:** ARBs in single pill combination (SPC) with calcium channel blocker (CCB) or diuretics were evaluated. The prices of the only reimbursed combinations were abstracted from the price list of the Turkish Ministry of Health. ARB type, dose increment regarding minimum available dose of ARB, CCB and diuretics in the market, being original drug and package size were analyzed as predictor in a regression model to estimate the price of the combination. **RESULTS:** In Turkey, 113 SPCs which include candesartan or eprosartan or irbesartan or losartan or olmesartan or telmisartan or valsartan as ARB, and hydrochlorothiazide as diuretic or amlodipine as CCB are currently reimbursed. The regression model showed that ARB type, dose increment in ARB and amlodipine and package size can be used to predict combination price (B=0.89, 4.01, 12.61 and 0.87 respectively; P<0.0001 for all). Being original drug or dose increment in HCTZ have no significant effect on price (B=-0.028, P=0.312; B<0.001, P=989, respectively). The model explains 92% of variance in drug price. The price of the amlodipine / valsartan 10/320 mg (28 package) is estimated to be 55.91 TL (24.59 Euro) (95% CI 52.46 – 59.12 TL) by using the formula. **CONCLUSIONS:** The formula can be used for estimating the price of the new SPC, when ARB type, ARB and amlodipine – if used in combination-, package size are known. Interestingly neither adding HCTZ nor being original drug affect price of the antihypertensive SPCs in Turkey.

PCV121

RELATIONSHIP BETWEEN PRIMARY CARE PHYSICIANS PROFILE, SELF-PERCEIVED HEALTH AND RECOMMENDATIONS TO THEIR PATIENTS

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OBJECTIVES: To describe primary care (PC) physicians' attitudes towards their health and work in order to segment them in typological groups, and to establish the relationship between self-perceived cardiovascular (CV) health of physicians with the recommendations to their patients. **METHODS:** Cross-sectional study, through a survey, on PC physicians in Spain. Data on socio-demographic, self-perceived CV risk and self-assessed consistency between recommendations and personal practice were collected. The attitude of physicians was estimated based on the degree of agreement to a set of given phrases. A cluster analysis was performed to identify population segments. **RESULTS:** A total of 2,583 physicians were recruited (53.4% women, mean±SD age 44.9±9.3 years), 77.6% of them had ≥10 years of professional experience. 76.6% perceived their current CV risk as low, 19.9% moderate and 3.5% high. The different physicians' attitudes clustered them into two general groups and five subgroups: 40% of physicians were classified as proactive and close to their patients (24% of them were seeing by the patients as an example, and 16% were strongly motivated and responsible), and 60% were grouped as distant and sceptical (20% reserved and distant, without influence of professional experience in self-care, 20% self-critical, sceptical that their knowledge and health may influence their patients, and 20% unmotivated and critical with the system). 76.6% of physicians considered to be fairly or completely consistent between what they did and what they recommended to their patients. Twenty-four percent of physicians with more years of experience were completely consistent vs. 18.7% with less experience (p<0.01). By gender, 24.3% of men were completely consistent vs. 21.6% of women (p<0.05). **CONCLUSIONS:** Only four out of ten physicians were close to their patients and eight considered having a low CV risk and declared to be consistent between what they do and what they recommend to their patients.

PCV122

HYPERTENSION AND DISABILITY-FREE LIFE EXPECTANCY FROM A COHORT STUDY IN JAPAN –RESULTS FROM A NATIONWIDE COHORT STUDY (NIPPON DATA80/90)

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OBJECTIVES: Hypertension is an established risk factor of cardiovascular disease. However, its impact on disability-free life expectancy (DFLE) is not well known, especially in Japan, which has the top-ranked life expectancy worldwide. **METHODS:** NIPPON DATA80 and NIPPON DATA90 were two nationwide cohort studies conducted in Japan, in which participants came from random-sample surveys in the years 1980 and 1990. The DFLE of each hypertension group at the age of 60 years was calculated using the Sullivan method. This estimation was based on age-specific mortality rates of each hypertension group, estimated by Poisson regression using NIPPON DATA80, and the disability prevalence of each hypertension group, estimated by logistic regression using NIPPON DATA90. To consider the effect of smoking on DFLE, we set conditions on the smoking status in the regression model. The blood pressure at baseline was used to categorize hypertension (mmHg, systolic blood pressure/diastolic blood pressure): optimal (<120/<80), prehypertension (120–139/80–89), hypertension I (140–159/90–99), and hypertension II (≥160/≥100). The disability prevalence was measured by the Katz activity of daily living scale. **RESULTS:** Among men/women who never smoked, DFLE (years) at age 60 was 21.1/21.9 for optimal hypertension, 20.9/21.6 for prehypertension, 19.8/20.8 for hypertension I, and 18.9/20.1 for hypertension II. This consistent decrease in hypertension grade was also observed in men and women who were currently smoking: DFLE (years) at age 60 was 19.0/21.0 (optimal), 18.7/20.7 (prehypertension), 17.6/19.9 (hypertension I), and 16.6/19.1 (hypertension II). **CONCLUSIONS:** In Japan, DFLE decreases as hypertension grade increases. A strategy for reducing hypertension is recommended to expand the DFLE in Japan.

PCV123

VIP STUDY: VENOUS THROMBOEMBOLISM PROPHYLAXIS PATTERNS AND DRUG USE IN PATIENTS UNDERGOING TOTAL KNEE AND HIP ARTHROPLASTY IN BRAZIL

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OBJECTIVES: To evaluate venous thromboembolism (VTE) prophylaxis pattern for total knee arthroplasty (TKA) and total hip arthroplasty (THA) in the context of Brazilian health care system. **METHODS:** Retrospective medical chart review study of patients undergoing elective TKA or THA in 2010. All charts were from either one public or two private hospitals in São Paulo, Brazil. Patients were 18+ years old, and excluded from the study if antithrombotic drugs were used prior to surgery. Descriptive analysis was performed through frequency distributions and mean/standard deviation (SD). **RESULTS:** From a total of 233 patients, 215 (92.3%) were included in the study: 121 (56.3%) TKA and 94 (43.7%) THA. Mean age was 68.2 (SD 9.8) years and 75.2% were female in the TKA group while, in the THA group mean age was 56.3 yrs (SD 15.6) and 53.2% were female.. From the public hospital, 71/81 (87.7%) patients received drug prophylaxis, being enoxaparin the choice of treatment. Enoxaparin onset mean time was 29hs after both surgery types. Mean inpatient treatment duration was 3 (TKA) and 4 days (THA). In private hospitals 132/134 (98.5%) received prophylaxis. Treatment of choice was enoxaparin in 130 (98.5%), while dabigatran and compression stocking in one case each. Compression stocking represented adjuvant prophylaxis in 16.7%. Onset mean time was 20hs after TKA and 17hs after THA for enoxaparin while 46hs for dabigatran. Mean inpatient treatment duration was 4 days(enoxaparin) and 3 days (dabigatran). **CONCLUSIONS:** The intra-hospitalar prevention rates of VTE in this study is within international (ENDORSE 2008), practice, while with lower rates in the public. There are uncertainties that outpatients received the same level of VTE prophylaxis. It is important to continue the awareness of the clinical and economic impact of VTE after orthopedic surgery, mainly in the outpatient care.

INFECTION - Clinical Outcomes Studies

PIN1

EFFECT OF ANTITUBERCOLOSIS TREATMENT ON LEVER ENZYMES

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Tuberculosis (TB) is one of the most common infectious diseases caused by Mycobacterium tuberculosis. The wide prevalence of tuberculosis all over the world makes it social and economical burden especially for developing countries and the use of anti tuberculous drugs is an optimistic approach for this problem.Certain adverse reaction associated with antituberculosis use need to be properly evaluated especially antituberculosis treatment induced liver injury and the hepatotoxicity. **OBJECTIVES:** Assessment of the severity and frequency of liver injury and hepatotoxicity caused by different anti-tuberculosis treatment drugs. **METHODS:** Seventy five patients randomly selected from newly diagnosed TB patients referred to Abo-Seta hospital in Tripoli, Libya for treatment during period from 1 January to 30 June. All patients received Directly Observation Treatment for Short period (DOTS) antituberculosis regime. Blood samples for liver function tests were obtain before starting the treatment and monthly assessment after starting the treatment for 6 months. **RESULTS:** In our study the patients developed ATT induced hepatotoxicities by increasing of all three enzymes 43.9% For alanine amino transferase (ALT), 36.6% for AST and 44.6% for ALK. Serious liver dysfunction in the first month compare with control sample, 36.25 ± 1.39 U/L, after one month increased to 64.6 ± 3.55 U/L, n= 75, (P < 0.05) from the sample before treatment. Alkaline phosphatase (ALP) shows increase after one month of treatment from 156.17 ± 21.35 U/L, after one month 281.83 ± 45.8 U/L, n= 75, (P < .05). **CONCLUSIONS:** There is significant increase in liver enzymes after starting of DOTS regime.