2006 were identified and categorized into two groups: with DM and without DM. Patients with complete insurance coverage and medication information 1-year prior and post the index hospitalization were included. Annual health care costs (in 2008 US dollars) and resource utilization were compared for both groups (All p < .001 unless otherwise specified). RESULTS: Of 12,502 patients who met the study criteria, 3,040 (24%) were diabetic and 9,462 (76%) were non-diabetic. Higher percent of diabetic patients had at least one all-cause rehospitalization event (49.0% vs 35.2%) or cardiovascular-related rehospitalization event (45.5% vs 32.3%). Mean length of stay (LOS) was longer for diabetic patients during the index hospitalization (4.3 days vs. 3.3 days), as well as during the rehospitalization event (all-cause: 4.6 days vs 3.3 days; cardiovascular-related: 4.6 days vs 3.2 days). In addition, patients with DM had more physician’s office visits (16.3 vs 12.4), ER visits (0.8 vs 0.5), and outpatient hospital visits (9.0 vs. 7.1) during the 12-month follow-up period. Both cohorts had similar index ACS hospitalization costs ($32,026 vs. $29,082) but diabetic patients incurred higher rehospitalization costs (all-cause: $19,913 vs $10,947; cardiovascular-related: $18,256 vs. $10,091), outpatient costs ($14,836 vs. $8,617) and pharmacy costs ($6,105 vs. $3,921). One-year follow-up health care costs were significantly higher for patients with DM compared with those without DM ($40,853 vs. $23,485). CONCLUSIONS: The presence of DM significantly increases health care costs and resource utilization for ACS patient.

PCV78

ONE-YEAR HEALTH CARE COSTS FOR ACUTE CORONARY SYNDROME PATIENTS WITH DIFFERENT TREATMENT STRATEGIES DURING THE INITIAL HOSPITALIZATION
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OBJECTIVES: This study calculated 1-year total health care costs for ACS patients and compared costs based on treatment strategy for patients during their initial hospitalization. METHODS: Commercially insured individuals, aged 18-64, participating in a large claims database were identified by a hospitalization with an ACS diagnosis between January 2004 and December 2005 with a 1-year follow-up period. Patients who had an ACS diagnosis in the prior 12-month to their initial ACS hospitalization were excluded. Patients were divided into 3 groups by treatment strategy during the initial hospitalization: MM, PCI or CABG. Multivariate linear regression was performed to assess the adjusted cost differences across these 3 groups. RESULTS: A total of 19,617 ACS patients were identified, of which 52% (n = 10,152) were managed by medical therapy, 40% (n = 7962) by PCI and 8% (n = 1539) by CABG. Mean length of stay and per-patient expenditures during the initial hospitalization for the MM, PCI and CABG groups were 1.9 days/108,875, 3.3 days/$31,990 and 9.3 days/$1,908, respectively. One year follow-up costs were $25,131/MM, $21,299 for PCI and $22,677 for CABG, where 46%, 42% and 46% of these costs were due to rehospitalization, and 4.7%, 10% and 5.9% were due to ACS-related prescription drug costs. Controlling for differences in demographics and clinical characteristics, CABG patients had approximately $32,365 greater 1-year total health care costs compared to MM patients (p < 0.001). Factors associated with increased costs included gender, age, comorbidities, initial hospitalization diagnosis, treatment strategy and prior health care costs. CONCLUSIONS: Total 1-year health care costs were higher for working-aged patients newly diagnosed with ACS and significantly different across the three treatment groups. Significantly higher costs were observed in patients managed interventionally, particularly by CABG, with the majority of these costs incurred during the initial hospitalization.

PCV79

BURDEN OF ILLNESS STUDY IN PATIENTS WITH RESISTANT HYPERTENSION IN UK
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OBJECTIVES: Resistant hypertension is defined as blood pressure (BP) that remains above goal in spite of the concurrent use of three antihypertensive agents from different classes. Some patients with resistant hypertension do not receive further treatment, potentially increasing the overall burden of disease on the health care system through increased health care use. To examine the burden of resistant hypertension to the health care system and explore the potential cost resulting from non-treatment of resistant hypertension. METHODS: The Health Improvement Network computerized data from 6.8 million patients in 382 practices was used to randomly select 9,000 patients with probable or confirmed resistant hypertension. Patients were characterized by number of therapies received according to NICE treatment guidelines (three therapies: step 3 vs. four or more, step 4). Blood pressure was used to classify patients as controlled or uncontrolled hypertension. Associations between covariates and patient status were examined using analysis of variance and logistic regressions. RESULTS: Mean age of patients with hypertension included in the study was 68.8 (SD = 11.5). Among patients in step 3 at baseline, 57.2% had uncontrolled BP (mean BP 151/81 vs. 127/77); among patients in step 4, 57.9% were uncontrolled (mean BP 153/84 vs. 128/77). 46% vs. 35.2% were followed for two years of follow-up, respectively. 25% of patients did not receive treatment recommended by NICE guidelines. Older male patients with diabetes or kidney disease were more likely to have resistant hypertension or uncontrolled BP at either step 3 or 4. CONCLUSIONS: A large proportion of patients with hypertension do not achieve BP control despite maintaining three or more antihypertensive therapies. The impact of not treating these patients with appropriate therapies can substantially contribute to overall burden of hypertension borne by the UK health care system.

PCV80

LONGITUDINAL COST IMPACT OF ATRIAL FIBRILLATION IN PATIENTS SUFFERING FROM CARDIOVASCULAR DISEASES
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OBJECTIVES: To examine the cost impact of atrial fibrillation (AFib) in patients with atherothrombotic diseases in a German statutory health insurance population. METHODS: Study design: A retrospective review of the medical, hospital and pharmacy claims data of a German statutory health insurance. We reviewed pharmacy and medical claims data for the years 2004-2005 from an insurance covering about 5 Mio insureds. The data of patients suffering from cardiovascular diseases (myocardial infarction, stroke or PAD) were available. By using the documented ICD-10 codes (I48.0, I48.11, I48.19) for hospitalizations we identified patients who experienced Afib during 2004 and 2005. For these patients we reviewed all the charges incurred for a one-year period after the initial index event on the basis of weekly costs and from the third party payer's perspective. RESULTS: A total of 14,798 patients (mean age: 72 ±10 years) with Afib could be included in the analysis. The majority of the patients (15%) were female. The cost for atrial fibrillation patients for one year was €7690. The largest portion of the total cost (78%) resulted from the costs for hospitalization while the initial hospital stay was associated with 30% of total costs. Approximately 100% of the study population received prescription drugs at an average cost of €115 per prescription drug. Comparing the total treatment before the initial diagnosis of Afib, the costs increase by the factor 1.4 during the first year after the event. The majority of costs one year after the event arise during the first 10 weeks (approx. 50%). CONCLUSIONS: An acute Afib-event in patients with atherothrombotic diseases represents a significant financial burden of the perspective of the statutory health insurance population. Improved management of the condition is needed to reduce the cost of treatment associated with Afib.

PCV81

ECONOMIC IMPLICATIONS OF OBESITY AMONG PEOPLE WITH ATEROTHROMBOTIC DISEASE IN AUSTRALIA
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OBJECTIVES: To measure the cost of disease from the governmental perspective of obesity among people with atherothrombotic diseases of coronary heart disease, stroke and PAD. METHODS: We reviewed pharmacy and medical claims data for the years 2004–2005 from an insurance covering about 5 Mio insureds. The data of patients suffering from cardiovascular diseases (myocardial infarction, stroke or PAD) were available. By using the documented ICD-10 codes (I48.0, I48.11, I48.19) for hospitalizations we identified patients who experienced Afib during 2004 and 2005. For these patients we reviewed all the charges incurred for a one-year period after the initial index event on the basis of weekly costs and from the third party payer's perspective. RESULTS: Annual pharmaceutical costs per person increased with increasing BMI, even after adjusting for gender, age, living place, formal education, smoking status, hypertension and diabetes. Adjusted annual pharmaceutical costs of overweight and obese patients were higher ($83 (p = 0.006) and $142 (p = 0.004), respectively) than those of the normal-weight patients. This was due to patients in higher BMI categories receiving more pharmaceuticals than normal-weight patients with the same condition. There was no significant change across the BMI categories in annual ambulatory care costs and annual hospital costs. CONCLUSIONS: In these patients with, or at high risk of, atherothrombotic disease, annual pharmaceutical costs were greater in patients with higher BMI, but there was no such gradient in annual hospital or ambulatory care costs. The greater cardiovascular pharmaceutical costs for patients of higher BMI remained even after adjusting for a range of demographic factors and comorbidities, and our results suggest that they are explained by a higher number of drugs used for the same condition. Further investigation is needed of the reasons for this level of drug utilisation.

PCV82

THE IMPACT OF LOST THERAPEUTIC BENEFIT (LTB) IN HIGH RISK PATIENTS MANAGED FOR HYPERTENSION IN AUSTRALIAN GENERAL PRACTICE
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OBJECTIVES: Lost Therapeutic Benefit (LTB) (receiving medication without attaining target BP levels) may lead to increased morbidity and mortality due to cardiovascular disease. Objectives of this study were to estimate the extent of LTB in patients at high risk of atherothrombotic events and to model the impact of attaining target BP levels in LTB patients on cardiovascular event rates over a two-year period. METHODS: The Australian REACH registry consists of 2872 high-risk patients of which 2856 (99.4%) were followed for cardiovascular events over a two-year period. The mean