on “restricted” status in 36.4% of hospitals. Guidelines for care of patients with ADHF were used in the emergency department (ED), inpatient care units, and outpatient clinics in 18.6%, 43.0% and 8.5% of hospitals respectively. Overall, ADHF care including general treatment as well as specific use of nesiritide was deemed to be appropriate in the majority of patients but nearly twice as many respondents perceived the management of ADHF and specific use of nesiritide was inappropriate in ED compared to the inpatient treatment. Only 41.1% of the respondents reported following Braunwald recommendations for the use of nesiritide. CONCLUSION: A sizable percentage of responding community hospitals did not have guidelines for treatment of ADHF despite existence of such in the literature. There are potential opportunities for improvement in the general treatment of ADHF as well as use of nesiritide in ADHF especially in the ED or observation unit versus inpatient.

CARDIOVASCULAR STUDIES—Methods & Concepts

PCV59 EFFECTIVENESS OF OUTPATIENT CLOPIDOGREL TREATMENT IN PREVENTING CARDIOVASCULAR EVENTS IN PATIENTS UNDERGOING STENTING FOR ACS: A RETROSPECTIVE CLAIMS DATABASE ANALYSIS Riedel AA, Chastek BJ, Wygant G, Hauch O
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OBJECTIVES: To evaluate outcomes of clopidogrel use following hospitalization for ACS in patients who had stent placement during the index hospitalization. METHODS: Retrospective administrative claims data from a geographically diverse US managed care organization (MCO) were used to identify patients ≥18 years of age, hospitalized with ACS diagnoses, treated with stent placement, and filling clopidogrel prescriptions within 7 days of discharge between 2000 and 2004 using ICD-9, CPT-4, and NDC codes. Exclusion criteria included ACS, anticoagulant or antiplatelet therapy 12 months prior to the index event, and use of anticoagulant or antiplatelet agents except aspirin and clopidogrel in the follow-up period. Clopidogrel exposure and non-exposure time following the index hospitalization were determined based on prescription data. Outcomes: Hospitalization for ischemic events (IE) and hospitalization or ER visits for bleeding episodes (BE) were determined using ICD-9 codes. Cox proportional-hazard regression controlled for clopidogrel exposure, age, gender, diabetes, hypertension, percutaneous transluminal coronary angioplasty (PTCA), and coronary artery bypass graft (CABG). RESULTS: A total of 9129 subjects, 79.3% male, mean age 54.6 ± 9 years, were identified. Mean follow-up time was 314 days, mean clopidogrel exposure time was 210 days, and mean non-exposure time was 303 days. IE rate was 8.7% during exposure and 9.1% during non-exposure; BE rates were 0.8% and 0.7%, respectively. Hazard ratio (HR) for IE during clopidogrel exposure was 0.87 [95% CI, 0.78–0.96; P = 0.007]. Other significant HRs were male gender (0.79; P < 0.001); diabetes (1.32; P = 0.001); and hypertension (1.13; P = 0.017). HR for BE during clopidogrel exposure was 1.46 [95% CI, 1.09–1.97; P = 0.012]; other significant HRs were hypertension (1.35; P = 0.041) and age (1.04; P < 0.001). CONCLUSION: This confirms clinical study findings that clopidogrel use reduces subsequent IE in ACS patients treated with stent placement, with a bleeding risk comparable to that observed in the CURE study. Longer treatment with clopidogrel could potentially reduce additional IE.