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SURVEY OF CURRENT ANTICOAGULANT MONITORING SERVICES IN THE UK—A GENERAL PRACTICE PERSPECTIVE

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OBJECTIVES: Quantify how anticoagulant (INR) monitoring is delivered in the UK NHS and understand the impact on general practice. **METHODS:** GPs subscribing to an online medical portal completed an electronic survey on delivery of INR monitoring for their AF patients (Sept 2004). **RESULTS:** GPs (n = 171) reported a mean of 122 patients with AF per practice, with 55% receiving anticoagulation. Most patients are monitored every month (50%) or more frequently (34%). Bloods are taken most commonly in general practice, either at a standard appointment (40%) or practice anticoagulation clinic (21%); the remainder at the hospital (36%) or at home (3%). Future warfarin dose is determined by the hospital (59%), GP (28%) or a nurse (14%) and then communicated to the patient by hospital staff (59%), nurse (20%), receptionist (15%) or GP (6%). Patients either wait for results and dosage instruction (27%), or receive these by telephone (32%), post (21%) or post and telephone (19%). Delays in patients commencing anticoagulation due to capacity of secondary care system were reported by 48% of GPs. In the 32% of GPs running a primary care anticoagulation clinic some were motivated by payments for the provision of additional services (25%) or a specialist interest (16%) but most were addressing a lack of centralised service i.e. hospital inaccessible (27%), no hospital or community outreach service (16%), hospital and/or outreach full (15%). Similar reasons were given by the 55% of practices that monitored patients in practice appointments. Despite a monthly mean of 42 practice appointments for monitoring, GPs felt any more than 28 per month were compromising other clinical workload. **CONCLUSIONS:** INR monitoring is complex involving a mixed primary/secondary care model. Availability and capacity issues in centralised monitoring clinics are the most common reason for primary care monitoring and this appears to affect other primary care clinical workloads.

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KNOWLEDGE AND USE OF TREATMENT GUIDELINES FOR STROKE PREVENTION OF PATIENTS WITH NONVALVULAR ATRIAL FIBRILLATION (AFIB) IN GERMANYBurkowitz J¹, Brüggjenjürgen B²

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OBJECTIVES: Treatment guidelines are an important source for estimation of resource use in pharmaco-economic models. Observance of recommendation in clinical practice is a possible element of uncertainty in the assessment of the results. For prevention of stroke in patients with nonvalvular atrial fibrillation (AFib) a number of national and international guidelines exist. Up to now there was a lack of studies which analysed the use of guidelines in prevention of stroke in Germany. **METHODS:** A telephone interview was conducted with a cross-section of GPs, internists and cardiologists randomly selected from a sub-set of 7072 out of the 59,953 office-based physicians of these specialties in Germany. A total of 75 completed surveys (15.1% of 498 eligible respondents) were completed. Beside questions on knowledge of the treatment guidelines the physicians were requested to assess three case vignettes with need of primary and secondary prevention strategies. **RESULTS:** A total of 22% of the physicians stated that they didn't know the national recom-

mendations for stroke prevention. Especially GPs were uninformed. Only 66% of the GPs shared the opinion that guidelines are helpful for their daily clinical practice. On the basis of presented fictive patients the physicians showed a high degree of uncertainty. The unambiguous cases were better rated by GPs, whereas more cardiologist and internists proposed treatments according to the guidelines in the more complex patients. In the primary prevention of stroke half of the respondents assessed treatments with ASS in contrast with the guidelines as sensible. In general physicians with higher qualification had better knowledge, but deficits exist independently from specialty. **CONCLUSION:** Results show heterogeneous use of treatment guidelines by German office-based physicians. In Germany, treatment guidelines don't reproduce the clinical practice and should be used as a reference in pharmaco-economic studies with caution.

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VKA TREATMENT RELATED COSTS IN FRANCE IN PATIENTS WITH CHRONIC NONVALVULAR ATRIAL FIBRILLATION: COST DATA FROM THE INTERNATIONAL STUDY OF ANTICOAGULATION MANAGEMENT (ISAM)Drouet L¹, Duru G², Mahe I¹, Bergmann JF¹, Bal dit Sollier C¹, Hollowel J³, Gauchoux R⁴, Woessner M⁵, Lamarque H⁵

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OBJECTIVE: Vitamin K antagonists (VKAs) have a narrow therapeutic window and numerous drug and food interactions and therefore require frequent INR monitoring. This study aimed to estimate VKA treatment related costs in patients with chronic nonvalvular atrial fibrillation (NVAf). **METHODS:** Data were collected as part of the French arm of ISAM—International Study of Anticoagulation Management. Cost analysis was from a societal perspective and limited to direct medical costs. A randomly selected sample of general practitioners (GPs) and cardiologists (43 GPs, 20 cardiologists) established a register of all patients who had received at least 60 consecutive days of VKA treatment for chronic NVAf in the preceding year. Study data came from medical records and patient interviews. VKA treatment related costs included INR tests, blood sample draws, physician consultations, nurse cost and VKA related hospitalisations. Drug costs were not considered. **RESULTS:** Of 278 patients interviewed, 264 patients had at least two consecutive INR results within the study period. In total, 3,026 INR tests were collected over a cumulative follow-up time of 188.4 years. The mean cost for INR tests was €164.8/patient/year (ppy); 41.2% of blood samples were taken at the patient's home by a nurse, with a mean driving distance of 4.6km, representing an additional cost of €6.3 for each INR taken at home (average €41.5/ppy). VKA treatment generated 630 GP and 171 cardiologist face-to-face consultations, at a cost of €87.8/ppy. Of 71 hospitalisations reported, 13 were judged attributable to VKAs by an event adjudication committee. These hospitalisations added a further €193.1/ppy. **CONCLUSIONS:** The annual cost of ambulatory VKA follow-up was €294.1 per patient. VKA related hospitalisations in this patient sample added €193.1, but the exclusion of patients unable to be interviewed may have resulted in underestimation of costs associated with severe and fatal adverse events (stroke).