CORRELATION OF WEIGHT TO CARDIOMETABOLIC RISK AS IDENTIFIED BY ICD-9 DIAGNOSIS CODES AND PRESCRIPTIONS IN PRIMARY CARE

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OBJECTIVES: This study evaluated the association of patients with a BMI > 27 kg/m² vs. a BMI *Y18 and *U27 kg/m² with cardiometabolic risk factors (CMRFs). METHODS: A retrospective review of an Electronic Medical Record database containing ambulatory health record data for a nationally representative sample of over 5 million US citizens with a BMI *Y18 kg/m² and *Y18 years of age was conducted. Patients with a valid BMI were included and stratified by no CMRFs or with one or more diagnoses or prescription orders associated with high triglycerides (TG), low high density lipoprotein (HDL), type 2 diabetes or hypertension two years prior to the last observation date. RESULTS: A total of 499,594 patients were identified in the study where 56% (281,988) had a BMI > 27 with a CMRF distribution of none (49.79%) one (35.36%) two (13.01%), three (1.70%) or four (0.14%). Of those with one risk factor 141,852 (31.29%) had hypertension, 10,866 (2.90%) had diabetes, 3667 (0.92%) had increased TGs and 1201 (0.26%) had low HDL. Compared to patients with no risk factors patients with 1-4 risk factors were significantly more likely to be in the >27 kg/m² group in all cases (p < 0.0001). Odds rations were 2.64 for hypertension, 2.21 for elevated triglycerides, 1.91 for diabetes and 1.45 for low HDL; 3.58 for any 2 risk factors, 4.24 for any 3 risk factors and 5.07 for all 4 risk factors, relative to having no CMRFs. CONCLUSION: Patients with CMRFs including hypertension, elevated triglycerides, diabetes or low HDL were anywhere from 5.07 to 1.45 times more likely to be have a BMI > 27. Diagnoses and treatments for CMRFs may be used as surrogate measures for the presence of obesity in claims data. Drugs that decrease both weight and improve CMRFs in such patients could be beneficial.

THE RELATIONSHIP BETWEEN OBESITY AND HEALTH-RELATED QUALITY OF LIFE IN PATIENTS WITH MODERATE TO SEVERE PSORIASIS OR RHEUMATOID ARTHRITIS

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OBJECTIVES: To explore the relationship between obesity and health-related quality of life (HRQoL) in patients with moderate to severe psoriasis (PsO) or rheumatoid arthritis (RA).

METHODS: A retrospective analysis on secondary clinical trial assessed 1205 PsO and 1988 RA patients using several approaches: (1) two univariate regression analyses [obesity predicting HRQoL; disease severity predicting HRQoL] and (2) a stepwise multivariate multiple regression analysis (MVA) to assess obesity as an independent predictor of HRQoL. Disease severity was measured using the PASI for PsO and DAS for RA. SF-36 was used for HRQoL assessment in both diseases.

RESULTS: Obesity and disease severity were found to be significant predictors of HRQoL. The stepwise MVA, using BMI, age, sex, disease duration and disease severity as predictors, revealed an overall significant effect in the PsO sample [components: L = 0.84, F (10, 2396) = 21.10, p < 0.0001; SF-36 domains: L = 0.73, F (40, 5198.6) = 9.54, p < 0.0001]. BMI added to the prediction of HRQoL over PASI for several SF-36 components and domains: PCS, MCS, PF, RE, SF, VT and MH. The results of the RA sample were similar: the overall MVA was significant [components: L = 0.74, F (10, 3962) = 64.05, p < 0.0001; SF-36 domains: L = 0.61, F (40, 8611.9) = 25.81]. Again, BMI added to the prediction of HRQoL over disease severity for MCS, PF and VT. Effect sizes in both samples were weak. CONCLUSION: Obesity was an independent predictor of HRQoL when using other covariates. This data indicates that reducing BMI and disease severity contribute significantly to the HRQoL of moderate to severe PsO and RA patients.

HOSPITAL COMPLIANCE WITH ACCP GUIDELINES FOR ANTICOAGULANT THERAPY AND JCAHO PERFORMANCE MEASURES

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OBJECTIVES: To (1) evaluate compliance with American College of Chest Physicians (ACCP) guidelines for anticoagulant therapy for prophylaxis or treatment of acute venous thromboembolism (VTE), and (2) to assess Joint Commission on Accreditation of Health care Organizations (JCAHO) performance measures for prevention and care of VTE.

METHODS: A retrospective chart review was performed by pharmacists at 32 community hospitals using an online standardized medication use evaluation form. Compliance with ACCP recommendations was assessed on the basis of dosage, duration and type of anticoagulant used. The following JCAHO performance measures were calculated using standard definitions: #5-Objective confirmation of clinically suspected VTE, #8-Anticoagulation overlap of parenteral and warfarin therapy for patients with VTE, #9-VTE patients with therapeutic International Normalized Ratio (INR), #10-Platelet count monitoring for patients with VTE receiving unfractionated heparin (UFH), #11-VTE patients on warfarin with any INR ratio > 6 during hospitalization, #12-VTE patients with a calculated creatinine clearance of <30 ml/min that received reduced medication dosage, #13-VTE treatment for discharged patients with active cancer, #14-UFH management by nomogram/protocol, and #16-VTE education (inpatient). Results were expressed as proportions.

RESULTS: A total of 902 cases were assessed. The mean age of the patients was 67.7 ± 16.9, 385 (42.7%) were males, and 104 (11.5%) had active cancer. 732 (81.2%) patients received prophylaxis of VTE while 170 (18.8%) received treatment for acute VTE. The average length of therapy and hospital stay was 5.7 ± 5.3 and 7.8 ± 7.2 days respectively. Anticoagulant therapy was consistent with ACCP recommendations in 78% of cases. Percent compliance with JCAHO measure #5, #8, #9, #10, #11, #12, #13, #14 and #16 were 82.9, 67.3, 28.0, 33.5, 0.0, 30.4, 14.7, 96.2, and 44.3 respectively. CONCLUSION: Anticoagulant therapy was in compliance with ACCP recommendations in majority of cases (78%). Performance with some JCAHO measures was less than optimal. Opportunities exist to improve the prevention and treatment of VTE.

COMPLIANCE AND PERSISTENCE WITH ASTHMA MEDICATIONS: IMPLICATIONS OF ASTHMA SEVERITY

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OBJECTIVES: To evaluate differences in medication compliance and persistence between patients with persistent (HP) and intermittent or non-persistent (HNP) asthma according to the Health