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 < 0.01 unless otherwise stated). RESULTS: OUT 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 compared to non-diabetic patients. 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 ($4,136 vs. $3,816) 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. $23,845). CONCLUSIONS: The presence of DM significantly increases health care costs and resource utilization for ACS patient.

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 database 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 (I48.10, I48.11, and 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 (55%) 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 €3155 per prescription drug user. Comparison of the medication 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 results in a significant financial impact from the perspective of the statutory health insurance population. Improved management of the condition is needed to reduce the cost of treatment associated with Af.

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 among patients with body mass index (BMI) higher than normal weight BMI. We used a bottom-up approach to cost estimation; and to explore the causes of any differences found. METHODS: The health care costs of obesity were estimated from 2819 participants recruited into the nation-wide Australian REACH Registry with established atherothrombotic disease or at least three risk factors for atherothrombosis. Enrolment was in 2004, through primary care general practices. Information was collected on the use of cardiovascular drugs, hospitalisations and ambulatory care services. ‘Bottom-up’ costing was undertaken by assigning unit costs to each health care item, based on Australian Government-reimbursed figures 2006–2007. General linear for working age and older patients were used to estimate associations between direct medical costs and BMI categories. 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 ($330 (p = 0.006) and $142 (p = 0.01), respectively) than those of the normal-weight patients. This was due to patients in higher BMI categories receiving more pharmaceutica 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.

PCV97 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 was 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 during the second year of follow-up. The study used a sequential cohort analysis. 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 v. 127/73); among patients in step 4, 57.9% were uncontrolled (mean BP 153/86 v. 129/72). After two years of follow-up, approximately 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.