morbidities play a major role in driving antidyslipidemic use in primary care setting.

**PCV80**

**DERIVING UTILITY VALUES FOR USE IN A MARKOV MODEL FOR EXPLORING THE CLINICAL CONSEQUENCES OF RIMONABANT IN ADDITION TO DIET AND EXERCISE IN OVERWEIGHT OR OBESE SUBJECTS**

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**OBJECTIVES:** SHAPE is designed to predict long-term clinical outcomes of management with rimonabant of cardiovascular risk in overweight or obese subjects. It is a lifetime Markov model with monthly cycles incorporating at risk, diabetes, cardiovasculardisease and mortality states, and using Framingham and UKPDS risk equations. The objective of this study was to derive utility estimates for the model’s health states based on patients similar to those in rimonabant’s trials.

**METHODS:** Mean health utility (EQ5D) values were obtained from 36,294 subjects in the Health Outcomes Data Repository Database (HODaR) of whom 4991 had either an MI, stroke, TIA or angina event with no previous inpatient history. The HODaR project collects data from patients who have attended the Cardiff and Vale NHS Trust in Wales. Utility values associated with specific BMI levels were also derived from multivariate analysis on subjects with a BMI ≥27 kg/m² adjusting for age, sex and diabetes status. **RESULTS:** Mean age-related health utility was 0.719 for an acute MI event, 0.709 for stroke, 0.698 for TIA, 0.709 for angina and 0.776 for diabetes (with no prior complications or inpatient history). Mean age adjusted utility decrements associated with these end points were 0.072, 0.185, 0.088, 0.126 and 0.041 for acute MI, stroke, TIA, angina and diabetes respectively. For BMI, a decrement of 0.014 utilities was estimated and this decrement reflects a 1 unit increase in BMI. **CONCLUSION:** This study provides contemporary and relevant utility values for cardiovascular modeling. The values were derived from clinical endpoints matching those included in the model and are well suited to models using Framingham or UKPDS risk equations.

**PCV81**

**VALIDATION OF THE MODE OF ADMINISTRATION OF THE MEDICATION COMPLIANCE QUESTIONNAIRE**

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**OBJECTIVES:** The Medication Compliance Questionnaire (MCQ) measures concepts that may be related to medication compliance by investigating subjects’ motivation, barriers, attitudes, and beliefs regarding compliance. In the current study, the MCQ was administered in The Netherlands primarily via postal survey. However, due to low response rate to postal surveys in Italy, the MCQ was planned to be administered there primarily via telephone interviews. The primary goal of the study was to evaluate the equivalence of the postal mode of the MCQ against the telephone interview mode, to determine whether the results could be compared across culturally. **METHODS:** Sixty subjects in Italy who responded to a postal administration of the MCQ were randomly assigned to one of two groups. Thirty subjects were administered the MCQ again approximately one week later by post and the remaining 30 subjects were administered the questionnaire again approximately one week later by telephone. **RESULTS:** As expected, results showed that the telephone mode of administration resulted in more complete data. Mail administration resulted in per item missing data rates of 3.3–23.3% while the phone administration yielded 100% response rates on all except one question, which was missing only one response. A difference in the consistency of responses across modes was found, with more consistency observed in the same mode between first and second administrations compared to alternate modes. There was also evidence of a response shift in the telephone administration mode including evidence for socially desirable response bias. **CONCLUSIONS:** Based on the results of this study, it is recommended that the results from the telephone administration not be considered equivalent to the mail administration without further examination. It is not advised to make direct comparisons of MCQ responses between countries without taking the potential impact of mode of administration into account.

**PCV82**

**VALIDATION OF A MODEL TO PREDICT LIFETIME CLINICAL AND ECONOMIC BENEFIT OF RAISING HDL-C IN STATIN-TREATED PATIENTS WITH PERSISTENTLY LOW HDL-C**

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**OBJECTIVE:** To help healthcare decision-makers assess the cost-effectiveness of HDL-c raising therapy, a model was developed to project lifetime clinical and economic benefits of adding an HDL-c raising drug in statin-treated patients with persistently low HDL-c. **METHODS:** We developed a simulation model made of two analytic decision sub-models. The first sub-model (Monte-Carlo) created a cohort of patients based on lipid levels after drug treatment. The second sub-model (Markov) estimated long-term clinical and cost outcomes (Framingham risk equations). Validation analyses were performed. **RESULTS:** Internal validation: in patients with no history of CVD, the model predicted a 2 years risk of CHD events of 1.12% and 2.02% risk for males and females respectively versus 1% and 2% in the Framingham study. In patients with a history of CVD, the model predicted 2-year risk of CHD events of 9.15% and 3.20% for males and females respectively versus 10 and 3.5% respectively in the published values. External validation: 1) in patients with low HDL-c, the model predicted a 2.32% risk for CHD events associated with each 1 mg/dL increment in HDL-c versus 2–3% in a published meta-analysis 2) by recreating the 4S cohort characteristics and simvastatin treatment effects, the model predicted cumulative incidences of 14.2% for non-fatal and 5.5% for fatal CHD events versus 15.9% and 5.0% in the 4S. **CONCLUSIONS:** Based on our validations, this computer simulation model appears to be a valuable and accurate tool to help evaluate HDL-c raising therapy for patients with persistently low HDL-c despite statin treatment.

**PCV83**

**COMPLIANCE PATTERN OF PHARMACOLOGICAL REGIMENS IN HYPERTENSIVES AND/OR DYSLIPIDEMIC PATIENTS IN AMBULATORY CARE IN A SPANISH POPULATION**

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**OBJECTIVES:** Lack of adherence is a major determinant of inadequate control of cardiovascular risk factors. The aim of this study is to evaluate the level of therapeutic compliance among patients with mild to moderate hypertension (HT) and/or dyslipidemia (DL), in a primary care setting in daily medical practice, and to determine factors associated with TC.
A retrospective multicentric study was performed from a one-year (2005) registry of patients from five primary care centres in Spain. Inclusion criteria were as follows: mild to moderate HT as per JNC-VII, British Hypertension-Society; and DL as per NCEP-ATP III. Compliance was estimated by the relationship between the amount of dispensed and prescribed pills. Demographic variables, comorbidities, clinical parameters and sanitary resources were registered. A bivariate analysis and a multiple linear regression analysis were done to correct the model.

RESULTS: Compliance was estimated from the total sample of 15,606 patients (HT: 41.7%; DL: 23.1%; HT/DL: 35.2%), in 85.9% (CI = 85.4–86.4%), 81.6% (CI = 81.0–82.2%) and 84.9% (CI = 84.3–85.5%) respectively (p = 0.000; Scheffé). Exploratory variables of a better compliance in the multivariate analysis were (beta = 0.832; t = 59.1; p = 0.000): a) direct relationship: age, labour inactivity, drug price, and b) indirect relationship: glycermia, triglycerides, LDL, and number of active principles used (p = 0.000).

CONCLUSION: Dyslipidemic patients show a worse compliance than hypertensive patients, and dyslipidemia worsened global compliance in hypertensive patients. Certain clinical parameters of control, the age of the patient and the drug group are related to compliance in daily medical practice.

PCV84
COMPLIANCE IMPROVEMENTS AND HDL CHOLESTEROL LEVELS IN HYPERTENSIVE PATIENTS IN SPAIN
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OBJECTIVE: Therapeutic compliance (TC) is related to risk control in the hypertensive patient. Nevertheless there is no much information on how the improvement of TC impacts on cardiovascular risk factors (CVRF), particularly on lipid parameters, in the Spanish hypertensive patients. To analyze the relationship among TC improvement (estimated by the relationship between amount of drug dispensed and amount of drug prescribed), and the variations in LDL-cholesterol (LDLc) and HDL-cholesterol (HDL-c) levels.

METHODS: Hypertensive patients from five Spanish primary care centres, who had registered values of LDLc and HDLc, between 2004 and 2005, were retrospectively studied. Changes in TC, LDLc and HDLc were calculated between mentioned years. Correlation between: a) changes in TC and HDLc, and b) changes in TC and HDLc, were calculated using the Spearman’s Rho test. RESULTS: Of the 6960 hypertensive patients, 5094 had registered HDL-c levels in 2004 and 2005. An increase in TC of 3.8% (DE:17.7%) was demonstrated. An inverse and statistically significant relationship between LDLc and TC (p = 0.003) was demonstrated. No relationship was found between TC improvement and HDLc (p = 0.9436). CONCLUSIONS: In the Spanish hypertensive population, CT improvements are associated to a decrease in LDLc levels, with no impact on HDL. Available treatments are not effective enough to improve HDLc levels in the Spanish hypertensive patient.

PCV85
COMPLIANCE AND PERSISTENCE OF FIXED DOSE VERSUS FREE DOSE COMBINATION THERAPY WITH VALSARTAN AND HCTZ FOR PATIENTS WITH HYPERTENSION
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OBJECTIVE: Blood pressure control can be difficult to achieve in hypertension, often requiring combination pharmacotherapy. A variety of approaches are available, including fixed dose combinations (FDC) versus individual components (IC). The purpose of this analysis was to assess combination valsartan and hydrochlorothiazide (HCTZ) therapy in previously antihypertensive naïve patients. METHODS: A national database of insured patients ages 18 & older with hypertension were evaluated for combination valsartan and HCTZ use initiated within 180 days of each other. Patients had at least two claims for this combination of pharmacotherapy within one year of their first prescription. Eligibility included continuous enrollment 110 days prior to first prescription and 365 days following dual therapy. Eligible patients were antihypertensive naïve 110 days prior to study drug initiation. Combination pharmacotherapy persistency at 365 days was calculated and sensitivity analysis was performed for the length of refill gaps. RESULTS: There were 2,022,578 unique patients age18 years or older identified with hypertension ICD-9 codes (401.0, 401.1, 401.9, 402.1 & 402.9). After applying study criteria there were 8711 eligible patients; 8150 FDC and 561 IC. In assessing ongoing persistence, patients could not have a refill gap in excess of 120% of previous prescription day’s supply. FDC persistency was 54% (4362/8150) compared to 19% (109/561) for IC at 365 days (p < 0.0001). Using a more stringent threshold (80% days supply), FDC was 44% (3623/8150) vs. IC 16% (91/561) p < 0.0001. Increasing the threshold (160% days supply) the FDC was 59% (4821/8150) vs. IC 21% (119/561) p < 0.0001. CONCLUSIONS: Use of FDC is more common (93.5%) than individual components for this previously naïve antihypertensive population. The fixed dose combination therapy group was shown to have significantly better persistence at 365 days vs. the individual components group, which proved to be quite robust following a sensitivity analysis.

PCV86
CHARACTERIZATION OF HYPERTENSIVE PATIENTS WHO MIGHT BENEFIT FROM A COMBINATION OF TWO DRUGS IN ONE PILL FOR REDUCTION OF CARdiovascular RISK
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Reduction of cardiovascular risk frequently requires the co-administration of multiple antihypertensive (AH) and lipid lowering (LL) drugs. Fixed combinations of two drugs could improve daily compliance by simplifying the treatment regimen. OBJECTIVE: To assess which antihypertensive patients might benefit from a combination of AH and LL drugs. METHODS: Hypertensive patients (>30 years plus >3 cardiovascular risk factors or events (CVD), experienced or new users of antihypertensive drugs between June 2003-June 2004 were selected from the IPCI database in The Netherlands. A written questionnaire was administered in October 2005 regarding reasons for non-compliance, likelihood of missing a dose if two pills would be combined in one, and self-reported medication-taking. Percentage of days covered (PDC) with AH medication was calculated from the prescription records. RESULTS: A total of 729 out of 1473 patients responded, 101 were new users of antihypertensive drugs, 349 had CVD. Respondents (75% male, median age 63 years) used on average 3 drugs, and 40% used LL drugs at start of follow-up. Side effects, lack of efficacy, and forgetting