ment with statins, suggesting a suboptimal use of resources. We studied the drug costs associated with overtreatment and the costs to eliminate undertreatment with statins in an elderly population. METHODS: Overtreatment and undertreatment with statins were ascertained using current Dutch cholesterol management guidelines. Data were acquired from the Rotterdam Study. This is a population-based prospective cohort study, which started in 1990 with 7983 participants of at least 55 years of age. This analysis focused on primary prevention of cardiovascular disease (CVD) excluding subjects with a history of cardiovascular disease. To estimate patterns of medication use in daily practice pharmacy records were obtained. RESULTS: From the 3251 participants 464 (14%) were still alive on January 1st 2002, had no history of CVD and were undertreated. Of the 565 participants starting statin treatment 389 (69%) were overtreated according to the same guidelines. After projection on the general Dutch population, the absolute costs for overtreatment with statins in 2005 were estimated to be approximately 23 million Euros (Uncertainty limits (UL): 19–28 million Euro), while the cost to eliminate undertreatment were also 23 million Euros (UL: 19–28 million Euros). CONCLUSION: In conclusion, when considering only drug costs reallocation of resources used for statin treatment from those overtreated to those undertreated could lead to a more efficient use of resources.

**THE ROLE OF ECONOMIC FACTORS IN THERAPEUTIC DECISION MAKING CONCERNING TREATMENT OF CORONARY ARTERY DISEASE IN POLAND**

Banasik W1, Jaworski R2, Czech M1, Pachocki R2
14th Military Hospital, Wroclaw, Poland, 2Servier Polska, Warsaw, Poland

OBJECTIVES: To identify key factors determining therapeutic decision making concerning coronary artery disease treatment in the GPs’ and specialists’ practices. To establish role of economic factors related. METHODS: A survey was conducted on the representative sample of Polish physicians (184 GPs and 63 specialists in the outpatient clinics) dealing with coronary artery disease (CAD) patients. Data were obtained with the aid of a specific questionnaire, including 6 items completed by doctor.

RESULTS: Choosing the treatment for a CAD patient, 75% of the GPs and specialists have taken drugs’ efficacy into consideration at first. Safety of treatment (GPs 9.8% and specialists 12.7% respectively) and adherence to guidelines (9.2%; 9.5%) were rarely considered as main factors. One third of the GPs and specialists declared that unbearable drugs’ costs constituted the most frequent reason for treatment discontinuation. The adverse events (20.6% and 20.1%) and poli-therapy (20.6% and 19.6%) were the next reasons cited. Treatment with the lowest priced drugs (75%; 74%) and those medicines administered once a day (75%; 71%) were described as two best ways of compliance improvement. The most important factors leading to the change of treatment were insufficient efficacy (88%) and adverse events (81%). 70% of GPs and 74% of specialists declared, that every third patient talked about economic issues of treatment (co-payment, costs of diagnostic procedures and additional doctors’ consultations). Only 31.5% of the GPs and 41.3% of specialists indicated an influence on the quality of life among the top three most important factors determining a therapeutic decision.

CONCLUSIONS: Factors determining therapeutic decisions in the CAD patients are quite similar among the GPs and specialists. Efficacy and safety of therapy represented factors commonly reported by the GPs as well as specialists. Unbearable cost of pharmacotherapy was considered as one of the main causes leading to treatment discontinuation and incompliance.

**LIPID TESTING AMONG PATIENTS RECEIVING FIRST-EVER STATIN THERAPY IN UK GENERAL PRACTICES**

Phatak H1, Wentworth C2, Burke TA1
1Rutgers University: The State University of New Jersey, Piscataway, NJ, USA, 2Analytic Consulting Solutions, Wakefield, RI, USA, 3Merck & Co, Inc, Whitehouse Station, NJ, USA

OBJECTIVE: Regular testing of total cholesterol (TC), high-density lipoprotein cholesterol (HDL-C) and triglycerides (TG) is important for effective lipid management. Our objective was to examine frequency of lipid testing and to assess predictors of lipid testing frequency in UK patients newly initiated on statins over a one year period. METHODS: This was a retrospective cohort study performed using the UK General Practice Research Database. Patients aged ≥35 years were included if they received their first ever statin between Jan-2000 and Dec-2004 and had at least one TC, HDL-C or TG test conducted in the one year period before statin initiation. Lipid tests performed after statin initiation were counted until the earliest of either one-year follow-up or statin discontinuation date plus 30 days. Poisson regression was used to assess pre-initiation factors associated with testing frequency for each lipid following statin initiation.

RESULTS: 57,296 patients received at least one TC, HDL-C or TG at baseline and had one year of follow-up after statin initiation. On average, patients received 1.3 ± 1.0 TC tests. However, 22.7% patients did not receive a single TC test after starting on statins. The mean number of tests per patient for HDL-C and TG was 0.9 ± 1.0 but 44.3% and 39.1% of patients did not receive a single HDL-C and TG test, respectively. In the multivariate analysis, high cardiovascular risk (OR, 1.04; 95% CI, 1.01–1.07) and baseline TC 26.2 mmol/L (OR, 1.1; 95% CI, 1.06–1.18, compared with TC <5.0 mmol/L) were associated with TC testing frequency. CONCLUSION: Higher cardiovascular risk and baseline TC were associated with TC testing within the first year following statin initiation. Lack of TC testing in approximately 2 in 10 UK patients during that period and infrequent HDL-C and TG testing may prove as barriers towards effective lipid management.

**A CARE MAP FOR CHF IN THE UK**

Knight CJ
Heron Evidence Development Ltd, Letchworth, UK

OBJECTIVES: To develop a care map for Congestive Heart Failure (CHF) in the UK, covering diagnosis, progression and treatment of patients, focussing on points of interaction with the UK NHS. METHODS: Available literature was searched for national and local clinical guidelines and treatment algorithms for CHF in the UK. Ten experts were consulted to validate and complete the dataset. An interactive 1-year care map of CHF care in the UK was then developed in MS Excel. New York Heart Association (NYHA) bands 1 to IV were used to group patients by disease severity and costs were estimated from an NHS perspective for 2005. Patient transition between hospital (including readmissions), home and nursing home was modelled. Possible surgical interventions were: heart transplantation, valve repair and ICD. Summary statistics included: Patient disposition and location after 1 year, total estimated costs (including where accrued) and hospitalisation rates due to CHF.

RESULTS: Over one year, 878,000 existing CHF patients plus 63,000 new cases would cost the NHS £896 million. The total spend (and percentage) on patients in hospital, at home and in nursing homes were £550 million (62%), £298 million (33%) and £47 million (5%) respectively. Surgery accounted for £13 million of hospital costs. Of 941,000 CHF patients, 291,000 will be hospitalised...