Longitudinal Health Insurance Database during 2000-2008. VTE cases were identified based on the diagnosis codes and on anticoagulant therapy or surgical thrombectomy procedure from the claims of inpatient or emergency care. Using risk set sampling, ten controls were selected for each case, matched on age (± 5 years), entry date (± 180 days), cancer diagnosis and major surgery procedures. The case group classified as better underdosing, and atypical antipsychotics (AAPs) was evaluated in the 365 days prior to an index date. Confounding was adjusted using a summary risk score for VTE during conditions, multiple logistic regressions. RESULTS: A total of 1,616 VTE cases and 16,028 controls were identified. Any use of TAs was associated with a 1.26-fold (95% CI, 1.16-1.50) increased VTE risk compared with nonuse. The risk varied depending on specific TAP-use scenarios, with the greatest risk being observed for parenteral dosing. Use of AAPs was associated with the 40 mg use of olanzapine-equivalent dose; OR adj, 1.75; 95% CI, 1.23-2.50), long-term use (> 30 days; OR, 1.59; 95% CI, 1.17-2.17), and current use of TAs (OR adj., 1.54; 95% CI, 1.03-2.27). Conversely, the insignificant association between AAP use and VTE risk was found and remained across the abovementioned drug-use conditions. CONCLUSIONS: Use of TAs but not AAPs is associated with an increased VTE risk. Health care professionals should be vigilant about VTE development in patients that use TAs, especially for those receiving parenteral administration or high doses of TAs.

PCV12 SIMVASTATIN AND ITS POTENTIAL DRUG INTERACTIONS: AN ANALYSIS OF SAFETY SIGNAL BASED ON FDA AERS DATABASE

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OBJECTIVES: Simvastatin is an antihyperlipidemic agent used to lower serum cholesterol. Simvastatin has been associated with rhabdomyolysis, a rare but potentially life-threatening Adverse Drug Event (ADE). While the FDA created a guideline limiting the use of simvastatin at higher doses, the objective of this study was to evaluate the data in the FDA Adverse Event Reporting System (FAERS) to describe and provide a quantitative analysis to this decision. A retrospective analysis of all domestic and foreign reports of simvastatin-associated rhabdomyolysis between October 1997 and September 2011 was conducted using FAERS database. The frequency of the following outcomes was examined: congenital anomaly, death, life-threatening event, hospitalization, disability, other, and required intervention. The percentage of role codes (primary suspect, secondary suspect, concomitant drug, or interacting drug) was analyzed. Separate analysis was conducted to report frequency of reports associated with rhabdomyolysis. Drug dosages associated with both ADEs and specifically rhabdomyolysis were evaluated. RESULTS: A total of 3,014,229 simvastatin-associated reports were identified over a 14-year period in the FAERS database. Hospitalization occurred in 41.1% and death was reported in 8.16%. In 6.36% of cases, both 40 mg and 13.4% for the 80mg dose. Simvastatin was designated as concomitant in 73.6% and as a secondary suspect in 16.0% of the cases. A total of 25,701 reports of simvastatin-associated rhabdomyolysis were reported. Of these, 6,673 rhabdomyolysis reports had dose information available. Whereas, 44.1% were associated with the 40 mg dose, 26.7% were reported for 80mg dose. CONCLUSIONS: Simvastatin-associated adverse events were demonstrated in the FAERS database with severe clinical outcomes including hospitalization and death. Patients diagnosed with rhabdomyolysis were increased when exposed to higher simvastatin doses provides evidence to support the FDA's black box warning.

PCV13 FACTORS PREDICTING BETA-BLOCKER TREATMENT AFTER MYOCARDIAL INFARCTION IN PATIENTS WITH TYPE 2 DIABETES

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OBJECTIVES: Beta-blockers remain important for secondary prevention after myocardial infarction (MI). Despite recommendations in clinical guidelines, the potential for poor glycomic control and difficulties in identifying warning signs of hypoglycemia limit their utilization in patients with type 2 diabetes (T2DM). To date, limited research evaluated differences in safety and efficacy based on differences in pharmacologic properties of beta-blockers. This study evaluated factors predicting post-MI beta-blocker utilization among T2DM patients. METHODS: A retrospective cohort of employed, commercially insured individuals with dependents was developed using de-identified patient enrollment files, medical claims, and pharmacy claims from 2007-2009. Inclusion criteria: (1) T2DM, (2) ≥ 18 years old, (3) continuous eligibility, (4) MI. Exclusion criteria: (1) females prescribed metformin exclusively without T2DM diagnosis codes, (2) < 6 months eligibility pre-MI, (3) MI before first T2DM date, (4) beta-blocker use pre-MI, (5) lack of comorbidity data. Bivariate statistics compared new beta-blocker users to non-users. Multivariate logistic regression with odds ratios (OR) and 95% confidence intervals (95%CI) with manual backwards elimination was used to evaluate demographic characteristics and comparabilities as predictors of post-MI beta-blocker exposure. RESULTS: Baseline characteristics were similar across the cohort with the cohort with 68.3% and 30.8% of new users receiving cardioselective and alpha-blocking beta-blockers, respectively. Congestive heart failure (CHF) without hypothyroidism (OR: 0.40; 95% CI: 0.29-0.55) and with CHF, arrhythmias, hypothyroidism, or renal failure were less likely to receive cardioselective beta-blockers post-MI. Although the results might not apply to older populations, our results support the need for further investigation to determine whether more T2DM patients could benefit from beta-blocker treatment post-MI.

PCV14 CHARACTERIZATION OF ISCHEMIC STROKE PATIENTS AND SECOND STROKE RATES BY RISK SCORES

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OBJECTIVES: Stroke is a leading cause of death and disability worldwide. Few studies have evaluated the risk of second stroke after a first ischemic stroke, which can be a measure of the ischemic stroke population with respect to cardiovascular risk factors. To better understand the ischemic stroke population with respect to cardiovascular risk factors, a standard electronic form. The other cohort (Registry cohort) included data obtained in the Brazilian Registry of hospital admissions systems (NH/RJ). To calculate the 30-day mortality data, were added through probabilistic linkage resorting to software ReLink 3. The rates comparisons were calculated using the Chi square test. The study was restricted to patients who had two forms of data collection, it shows that the mortality rate is even higher when collected directly from the hospitals. It can be explained by a selection bias of patients for inclusion in the registry. The use of secondary data for economic analyses may lead to an underestimation of the mortality rates in CABS. It is frequently stated that records for reimbursement purposes may show higher mortality rates than what actually occurs. Among other causes, it may occur out of intention and the technical mishandling of the register (e.g. by including only severe cases) or due to lack of knowledge on how to register the data. The aim of the study was to evaluate the accuracy of a public registry system concerning hospital mortality in coronary artery bypass surgery (CABS). METHODS: The hospital cohort was composed by a retrospective cohort sample of all adults undergoing CABS on the State of Rio de Janeiro, Brazil, from January to December 2007. One cohort obtained the data directly in the hospitals (in-hospital mortality) through chart review using a standardized electronic form. The other cohort (Registry cohort) included data obtained in the Brazilian Registry of hospital admissions systems (NH/I/RJ). To calculate the 30-day mortality data, were added through probabilistic linkage resorting to software ReLink 3. The rates comparisons were calculated using the Chi square test. The study was restricted to patients who had two forms of data collection, it shows that the mortality rate is even higher when collected directly from the hospitals. It can be explained by a selection bias of patients for inclusion in the registry. The use of secondary data for economic analyses may lead to an underestimation of the mortality rates in CABS.

PCV16 COMPARATIVE EFFECTIVENESS OF ROSUVASTATIN VERSUS OTHER STATINS ON LDL-CHOLESTEROL (LDL-C) REDUCTION IN HIGH RISK PATIENTS

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OBJECTIVES: To compare effectiveness of initiation of different statins on LDL-C reduction among high cardiovascular-risk patients. METHODS: Patients aged ≥ 18 years and newly initiating statin therapy (rosuvastatin, atorvastatin, simvastatin, or pravastatin) were identified from the HealthCare Integrated Research Environment (HIRE) from 1/1/2007-2/28/2013. Patients were required to have ≥ 2 LDL-C values (one pre- and post statin initiation). Patients were classified as high risk (coronary heart disease [CHD] or CHD risk equivalent) based on NCEP ATP III guidelines and were propensity score matched on several baseline characteristics. Absolute change from baseline to most recent LDL-C values obtained in the follow-up period and propensity scores were used to compare 5% of all cases in the overall group versus rosuvastatin versus the other statins grouped together and versus atorvastatin alone. RESULTS: There were 625 matched high-risk patients in both the rosuvastatin group and the overall group with the other statins grouped together. Average follow-up was 259 (rosuvastatin) vs. 263 (overall days) and 264 (rosuvastatin) vs. 239 (atorvastatin) days. Mean baseline LDL-C value was 130 mg/dL (rosuvastatin) vs. 128 mg/dL (overall) and 131 mg/dL (rosuvastatin) vs. 126 mg/dL (atorvastatin). LDL-C values for both groups increased by 24% to 29% after 180 days, 21 mg for the overall group, and 21 mg for atorvastatin. Absolute reduction in LDL-C was higher for the rosuvastatin group compared to either the overall group (52 vs 43 mg/dL, p = 0.0001) or the atorvastatin group (53 vs 47 mg/dL, p = 0.003). Propensity of patients attaining ≥50% reduction in LDL-C was significantly higher for the rosuvastatin versus the