divided by the total number of days). **RESULTS:** Most of the 62,754 beneficiaries had an index prescription of BETA, followed by ACEi, DIU, CCB, and ARB. Persistence rates at 180 and 360 days were highest for ARB (71.0 and 52.7%, valsartan 77.1 and 59.3%), followed by CCB (51.5 and 34.4%), ACEi (50.2 and 34.5%), DIU (41.3 and 26.0%), and BETA (25.1 and 13.6%). After adjusting for age, sex, and diabetic comorbidity, the persistence remained significantly higher for ARB compared to all other drug classes. The MPR for 180 and 360 days showed a similar pattern with the highest ratio for ARB (0.88 and 0.84; valsartan 0.92 and 0.87), followed by CCB (0.73 and 0.66), ACEi (0.72 and 0.67), DIU (0.70 and 0.63), and BETA (0.51 and 0.45). **CONCLUSION:** ARBs, and valsartan as a representative of the class, showed the highest persistence and compliance suggesting that a more sustained blood pressure control could be expected from utilization of ARBs and Valsartan.

PCV67

FACTORS DETERMINING COMPLIANCE IN PATIENTS WITH HIGH CARDIOVASCULAR RISK IN DAILY CLINICAL PRACTICE

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Lack of compliance is a major factor responsible for the differences between clinical trial results and real effectiveness in daily medical practice, contributing to an insufficient control of the cardiovascular risk factors (CVRF). Knowledge of the factors contributing to lack of compliance is limited, and in Spain data are scarce. **OBJECTIVES:** 1) To indirectly determine the level of compliance among patients with hypertension and/or dyslipidemia; 2) To determine factors associated with compliance. **Patients and METHODS:** A total of 9001 hypertensive and/or dyslipidemic patients from four primary care centres in Catalonia were enrolled in Disease Management programmes during the previous four years. Compliance was estimated by the relationship between the amount of dispensed and prescribed pills. 1) The levels of compliance of dyslipidemic patients without hypertension (DL-non HT), hypertensive patients with dyslipidemia (HT + DL) and hypertensives without dyslipidemia (HT-non DL) were compared. 2) An stepwise, multivariate, descriptive; multiple regression model was designed in order to explain compliance. **RESULTS:** 1) Compliance was 79% in DL-non HT, significantly lower than in HT + DL (81.2%, $p < 0.0001$) and in HT-non DL (82.4%, $p < 0.0001$). There were also statistically significant differences between these last two groups ($p = 0.0014$). 2) Explanatory variables of a better compliance in the multivariate analysis were a) patient related factors: labour inactivity ($p < 0.0001$); b) management related factors: specific doctor ($p < 0.0001$) and intensity of follow-up ($p = 0.04$) and c) drug related factors: the drug group ($p < 0.0001$); the drug price (the more price the more compliance ($p = 0.0062$) and the number of active principles used (the more number the more compliance, $p = 0.019$). **CONCLUSIONS:** 1) Dyslipidemic patients show a worse compliance than hypertensive patients, and dyslipidemia worsened global compliance in hypertensive patients. 2) Patient characteristics, doctor attitude, follow-up intensity, drug group and simplicity of treatment are related to compliance in daily medical practice.

PCV68

COST-EFFECTIVENESS OF RAISING HDL-C WITH PROLONGED-RELEASE NICOTINIC ACID (NIASPAN®) IN STATIN-TREATED PATIENTS WITH PERSISTENT DYSLIPIDEMIA IN AUSTRIAN, SWEDISH AND NORWEGIAN SETTINGS

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OBJECTIVES: To evaluate the long-term clinical and cost outcomes of adding Niaspan® to statin treatment in patients with persistently low HDL-c on statin monotherapy. **METHODS:** Two models were developed to project long-term clinical and economic outcomes. The first model (second order Monte Carlo simulation) simulated the evolution of lipid levels with treatment and the second (Markov model) was designed to calculate the risk of coronary heart disease (CHD) events each subsequent year. Transition probabilities for CHD events were derived from the Framingham risk formulae. Baseline cohort characteristics and simvastatin treatment effects were taken from the 4S lipid triad sub-group. Patients with persistently low HDL-c (<1.03 mmol/L) on statin treatment received either add-on Niaspan® 1 g to 2 g daily or continued statin monotherapy. Niaspan® dosing followed maintenance dose recommendations and treatment effects were taken from several clinical trials (European SPC). Direct medical costs were accounted (cardiovascular complications and drug costs). Annual discount rates of 0% and 3.5% (Austria), 3% (Sweden and Norway) were applied to clinical outcomes and costs. **RESULTS:** 68.9% of patients were projected to have persistently low HDL-c levels after statin treatment. In these patients mean undiscounted life expectancies (LE) of 20.96 years and 20.46 years were projected for the Niaspan® and statin monotherapy arms respectively. Lifetime direct medical costs were higher by €8079 in Austria, €4723 in Sweden and €5638 in Norway with addition of Niaspan®. Incremental cost-effectiveness ratios based on discounted LE were €16,306 (€17,635) per life year gained in Austria, €16,543 (€16,652) in Sweden and €19,748 (€21,194) in Norway for statin plus Niaspan® 1 g (and 2 g) versus statin monotherapy. **CONCLUSIONS:** In Austria, Sweden and Norway, raising HDL-c with the addition of Niaspan® to statin therapy was projected to be cost-effective compared to statin monotherapy in patients with dyslipidemia and persistently low HDL-c.

PCV69

COST-EFFECTIVENESS OF ADD-ON THERAPY WITH PROLONGED-RELEASE NICOTINIC ACID (NIASPAN®) IN STATIN-TREATED PATIENTS WITH DYSLIPIDEMIA AND PERSISTENTLY LOW HDL-C IN THE UK AND GERMANY

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OBJECTIVES: To evaluate the long-term clinical and cost outcomes of adding Niaspan® to statin treatment in patients with persistently low HDL-c on statin monotherapy. **METHODS:** Two models were developed to project long-term clinical and economic benefits of treatment. The first simulated the evolution of lipid levels with treatment utilising second order Monte Carlo methodology, and the second was designed to calculate the risk of coronary heart disease (CHD) events each subsequent year using standard Markov modeling techniques. Transition proba-