treated with statins tend to present less (44%) asymptomatic PAD than other patients
(OR 0.56, 95% CI 0.3–0.95 p = 0.07). Seventy-four percent of patients were aware of their CV risk, and smoking, high cholesterol, over-weight and hypertension were identified by patients as the most important factors increasing the risk on CV risk-adjustment.

Aims: Asymptomatic PAD in subjects without CVD but at moderate risk was less prevalent in Belgium than in the other European countries, but was still significantly correlated with classical CVD risk factors, especially smoking, hypertension, lipid profile and age. It could be advisable to identify patients with such risk factors through ABI measurement and treat them accordingly as high risk individuals.

OBJECTIVES: To compare 5-year cardiovascular (CV) event reduction between patients treated with generic simvastatin therapy (ST) and niacin extended-release [NER] + simvastatin (NERS) combination therapy among primary and secondary risk patients from a managed care organization’s perspective. METHODS: Two hypotheti-
cal managed care formularies, each consisting of 1,000,000 primary and secondary risk patients from a managed care organization were modeled over a five year timeframe: a current formulary, where all patients were treated with ST and a revised formulary where all the patients were treated with NERS. Study patients with sub-optimal LDL-C, HDL-C, and/or TG at baseline were sampled from the HealthCore Integrated Research Database between January 1, 2000 and February 28, 2005. Package insert efficacy of lipid medications in each formulary was applied to the study population. Post-treatment lipid values were evaluated according to U.S. lipid guidelines. Incremental reduction in CV events [myocardial infarction (MI), peripheral vascular disease (PVD), and stroke] among NERS treated patients versus ST patients was estimated. Markov share of NERS over five years was assumed to be 1.5%. RESULTS: A total of 529,620 study patients were identified, having a mean age of 54 ± 11 years, 45% female, and Deyo-Chlson comorbidity score of 0.38 ± 0.42. Patients treated with NEROS therapy demonstrated an incremental reduction of 1,515 CV events (e.g. 218 vs. 28,733) over 5 years compared to ST. Incremental reduction in stroke events in the same period were found to be 564 (10,144 vs. 10,708), MI events reduced by 631 (11,341 vs. 11,972), while PVD events reduced by 319 (5,733 vs. 6,052). CONCLUSIONS: Treatment with NERS therapy with primary and secondary risk dyslipidemia patients was associated with 5-year reductions in CV events compared to ST treated patients. Further studies assessing the addition of NER to ST or switching ST treated patients to NER/S therapy on clinical and economic outcomes are needed.

Effectiveness of ARBs in reducing mortality did not differ from that of an ACEI or a CCB. Amongst the ARB-treated patients from a managed care organization’s perspective. METHODS: A retrospective study of the Southwestern Ontario database which contains chart-
retrospective data on patients with hypertension was identified as those with a recorded Blood Pressure (BP) exceeding 140/90 mmHg, chart entry of a diagnosis of hypertension, or use of anti-hypertensive medication. Patients treated either in mono or dual therapy with angiotensin II receptor blockers (ARBs), ACE inhibitors (ACEIs) and Calcium Channel Blockers (CCBs) were included. The number of patients who experienced at least one CV event from 2003 to 2008 was recorded. CV events are stroke, myocardial infarction, congestive heart failure, peripheral vascular disease, coronary heart disease, atrial fibrillation or transient cerebral ischemic attack. Due to the well known com-
parable safety profile of the compounds, a safety analysis was not performed.

RESULTS: A total of 53,064 patients treated with an ARB, ACEI or CCB in mono or dual therapy were identified. The proportions of treated patients who experienced a CV event were 4.3% on ARBs compared to 7.0% on ACEIs and 7.4% on CCBs. These differences were statistically significant (p < 0.001). Within the ARB class, the proportions of treated patients who experienced a CV event were 3.0% on irbesartan compared to 4.6% on losartan, 5.0% on valsartan and 5.0% on candesartan. These differences were statistically significant (p < 0.002). CONCLUSIONS: In patients treated in mono or dual therapy, those treated with an ARB experienced significantly fewer CV events than those treated with an ACEI or a CCB. Amongst the ARB-treated patients, those treated with irbesartan as part of their therapy experienced significantly less CV events than those treated with another ARB.