   Abbreviated title (length 26): Trends in aspirin use in AMI

2. Writing Group (list individual with lead responsibility first):
   Lead: Michael O'Reilly, MD
   Address: Inst. for the Generalist; UNC-Chapel Hill, CB#7595; NC 27599
   Phone: (919) 966-0925                    FAX: (919) 966-0536
   Email: oreilly@med.unc.edu

   Wayne Rosamond                  Aaron Folsom
   Lawton Cooper                  Limin Clegg

3. Timeline:
   Analyses are expected to be completed within 6 months; a draft manuscript will be presented to the group within two months after the completion of the analysis.

4. Rationale:
   Since ISIS-2 (published in 1988), aspirin has been widely acknowledged to decrease mortality in the setting of acute myocardial infarction (MI). Fortunately this therapy is inexpensive, and relatively few patients have contraindications to aspirin use. Previous studies have indicated that aspirin therapy in AMI has increased since the publication of ISIS-2, but suggest that aspirin may still be underutilized. Racial differences in the utilization of aspirin therapy have not been well studied.

   Previous studies suggest that the utilization of certain treatments and technologies - for example, angioplasty and cardiac catheterization - is evidence of a multi-tiered system of treatment, utilization of interventional treatments showed persistent racial differences. Issues of cost fade in the VA setting, but issues of consent in invasive procedures (which involves black patients' trust of largely white medical establishments) complicate the study's conclusions. In studying aspirin therapy, neither cost nor consent are likely to be significant. By taking into account the site of treatment, we can evaluate results for potential confounding by geographic location.

   In the same year that studies on aspirin therapy's efficacy were published, two published studies demonstrated a lack of benefit of CCBs in the AMI setting. This study will also examine current trends in Calcium Channel Blockers and Beta Blockers in the setting of AMI.

   In addition to examining racial difference in aspirin utilization, age and gender of patients will also be described.

5. Main Hypothesis:
   1) There is a difference in utilization of aspirin therapy in the setting of acute MI by race and gender; 2) There is a trend in time towards greater utilization of aspirin among all patients.

6. Data (variables, time window, source, inclusions/exclusions):
ARIC surveillance data (1987-1993) will be used for analyses. Among patients with probably of definite MI, the main variables include in-hospital and discharge medications (aspirin, warfarin, beta blockers, calcium channel blockers), race, gender, and geographic site of hospital. Other variables include ICD-9 codes for coagulopathy, stroke, end stage liver disease and peptic ulcer disease; procedures; and type of hospital (teaching vs. non teaching).