Abstracts

ASSOCIATION AND CONTROL OF MAIN CARDIOVASCULAR RISK FACTORS IN A SPANISH POPULATION SECTOR; A CROSS-SECTIONAL STUDY
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OBJECTIVES: To evaluate the degree of interrelation among cardiovascular risk factors (CVRF), and routine achievement of some therapeutic goals for modifiable CVRF in primary care settings. METHODS: Multicentric-retrospective study. Data were obtained from 5 primary care setting clinic records (patients >30 years old) during 2006. Patients were divided into 8 groups, including combinations of the three main modifiable CVRF. Criteria: NCEP-ATP III modified. Main measures: cardiovascular/general diagnostics, cardiovascular events (CVE), clinical parameters (systolic and diastolic blood pressure, cholesterol levels, LDLc levels, etc) and costs (semi fixed/variable, tests, derivation, drugs). ANCOVA analyses were developed (Bonferroni adjust) to correct the model. SPSS program was used. A significance level of = 0.05 was used

RESULTS: In total, 57,025 patients were studied; age: 54.3 ± 16.2 years old, 54.8% women; CVE: 8.8%. Distribution by groups: a) population: 55.3% (n = 31,554; age: 47.2 ± 14.1 years old; women: 55.7%; ECV: 3.1%), b) Hypertension (HT): 11.6% (n = 6627; age: 66.9 ± 13.8 years old; women: 57.4%; CVE: 14.4%), c) Diabetes Mellitus DM: 2.6% (n = 1463; age: 60.1 ± 16.4 years old; women: 44.4%; CVE: 16.8%), d) Dyslipidemia (DL): 13.7% (n = 7811; age: 55.2 ± 13.2 years old; women: 50.5%; CVE: 8.2%), e) HT-DM: 2.8% (n = 1624; age: 71.2 ± 11.8 years old; women: 55.5%; CVE: 25.4%), f) HT-DL: 8.3% (n = 4707; age: 66.5 ± 11.7 years old; women: 57.3%; CVE: 19.1%), g) DM-DL: 1.9% (n = 1058; age: 63.5 ± 11.8 years old; women: 41.7%; ECV: 23.3%) y h) HT-DM-DL: 3.8% (n = 2179; age: 69.1 ± 10.2 years old; women: 55.5%; CVE: 30.6%), p < 0.001. DM-DL and HT-DM-DL groups had the worst metabolic controls. All components of costs were higher in the HT-DM and HT-DM-DL groups; 1543.60 ± 1233.33 y 1739.07 ± 1192.36, respectively (p < 0.001). CONCLUSION: Diabetes mellitus is the main risk factor (greater presence in CVE) and is associated with worse metabolic status and higher cost of care. Achievement of established therapeutic goals must be improved in primary care.

PCV10

MULTIPLE REGRESSION ANALYSIS MODEL PREDICTED DIASTOLIC BLOOD PRESSURE
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OBJECTIVES: 1) To find efficiency Hierarchical Stepwise Multiple Regression Analysis model that predict diastolic blood pressure. 2.) To find correlation between calories burnt by exercise, compliance, eating behavior score, hypertension knowledge and diastolic blood pressure. METHODS: A cross-sectional clinical and survey study by face to face interview with questionnaire was employed to investigate relationship between health behavior factors namely—calories burnt by exercise, compliance, eating behavior score, smoking, drinking, demographic data and diastolic blood pressure of 200 hypertensive patients at Adisorn Hospital selected by convenient sampling. RESULTS: Total sample size (n = 200, 100%) of hypertension patients, mostly 113 (56.50%) were female, 87 (43.50%) were male with average age 57.29 ± 13.16 years, Average BMI 27.52 ± 3.84, Average total calories burnt per week 1749.68 ± 3948.43. Average compliance score 7.85 ± 2.12. Average hypertension knowledge score 7.06 ± 0.58. Average eating behavior score 6.91 ± 1.97, and average Diastolic 94.11 ± 11.11. Compliance score and hypertension knowledge had significantly correlated with Diastolic (r = 0.97, -0.13, p < 0.01). Hierarchical stepwise Multiple Regression Analysis confirmed that 3 factors—calories burnt by exercise, compliance score and age were significantly predictors of Diastolic (Beta = 0.56, 0.42, 0.05, p < 0.01, R Square = 0.86).

CONCLUSION: Hierarchical Stepwise Multiple Regression Analysis confirmed that calories burnt by exercise, compliance and age were three significantly factors predicted diastolic blood pressure.

PCV12

USING ADMINISTRATIVE DATA FOR QUALITY INDICATORS OF AMI HOSPITAL CARE IN HUNGARY
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OBJECTIVES: The aim of our study is to analyse the validity of administrative data and the appropriateness, accessibility and effectiveness of acute myocardial infarction (AMI) care. METHODS: Data derive from the nationwide database of the National Health Insurance Fund Administration (OEP). Our tudy includes patients admitted to a hospital between 2000 and 2005 due to AMI (ICD 10, I21 or I22) or were treated by reperfusion or revascularisation therapy (PCI, thrombolysis, CABG—intervention group). The mortality data was derived from death certificates. We analysed the role of risk factors by logistic regression. RESULTS: From 2000 until 2005 the number of AMI cases has increased from 14089 to 16296 (n = 92902) while the 30-day mortality of AMI cases decreased from 20.9% to 19.2% (P < 0.001). In 2000, 30.3% of the AMI cases were treated with PCI, thrombolysis or CABG, this proportion