Objective: To compare vascular risk factor profiles and early outcomes in all French patients hospitalized for either acute coronary (ACS), or cerebrovascular syndromes (CVS), or both, between 2005 and 2008.

Setting: All French hospitals.

Design: Retrospective analysis.

Data sources: National database called “Hospital Discharge Diagnosis Records”.

Main outcomes measured: Number and annual rates, vascular risk factors, and early outcome of hospitalized patients for a unique stay for ACS or CVS or for both ACS and CVS in a 2-month time window.

Results: Over the 4-year study period, 1,189,043 patients were hospitalized for CVS and/or ACS. Among these, 638,061 (53.7%) had CVS alone, 525,419 (44.3%) had ACS alone, and 24,163 (2%) had both. Patients of the latter group were older (75.2 ± 12 years), and had a higher prevalence of hypertension (50.8%), diabetes (26.3%), and atrial fibrillation (23.9%) (p<0.001). In contrast, the prevalence of obesity (9.6%) and hypercholesterolemia (25.7%) was greater in ACS only patients. Patients with both CVS and ACS had a longer length of stay (16.1 days), and were less likely to be discharged to home. These patients also had a higher in-hospital risk of death, in men and in women (Figure). This risk remained after adjustment for age, sex, and vascular risk factors compared with patients with either CVS alone (OR=1.71, 95% CI: 1.66-1.77) or ACS alone (OR=2.95, 95% CI: 2.85-3.05).

Conclusion: Our study conducted in almost 1.2 million hospitalized patients provides clear evidence that patients with both CVS and ACS have a high vascular risk profile and a marked excess risk of early death.
Physicians evaluation mismatched with Framingham for 50% of the patients and 27% were under-evaluated. Evaluation mismatched with SCORE for 53% of the patients, 38% were under-evaluated. Within the 25% of the patients having a Framingham score >20% and without a lipid lowering treatment, 70% was under evaluated by physicians. Within the 38% of the patients having a SCORE calculation 5% and without a lipid lowering treatment, 78% were under evaluated.

Explanatory factors for under-evaluation in primary prevention according to SCORE

<table>
<thead>
<tr>
<th>Evaluated (%)</th>
<th>Framingham (%)</th>
<th>Score (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>40</td>
<td>41</td>
</tr>
<tr>
<td>Medium</td>
<td>37</td>
<td>24</td>
</tr>
<tr>
<td>High</td>
<td>23</td>
<td>35</td>
</tr>
</tbody>
</table>

Conclusion: This study underlines the mismatch between GP perceived CVR and calculated CVR, especially for high CVR patient. Males, patients with treated HBP and with high LDL-c were at increased risk of CVR under-evaluation.

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Adherence to dual antiplatelet therapy after myocardial infarction: results from a french health insurance reimbursement database

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Background: The French guidelines recommend dual antiplatelet therapy after acute myocardial infarction (MI).

Purpose: To estimate persistence of dual antiplatelet therapy after MI. Methods: A cohort study was conducted using data from the main French health insurance reimbursement database of the Aquitaine region (southwest France). Patients who had been hospitalized for MI in 2008 were first identified. Then, we looked for their reimbursement form of dual antiplatelet therapy (aspirin+clopidogrel) treatment for the following 12 months. Adherence was assessed by using two parameters: proportion of days covered by the treatment (medication availability) and persistence. The treatment persistence was the percentage of patients still treated at the end of the period. Discontinuation was defined as a minimum gap of 30 days between the theoretical end date of prescription reimbursed (based on a days’ supply) and the starting date of the next one.

Results: Among the 634 patients identified, 40 had no reimbursement of dual antiplatelet therapy immediately after discharge. At three month, 15.2% of the remaining patients did not buy at least one of the two treatments. They were 48.2% at 12 months although the medication availability was 90%. Conclusion: Theses results suggest that while the patients have good medication availability, the treatment is often stopped before one year. At three months after MI, 20.6% of the patients were no longer treated with dual antiplatelet therapy. The results presented are likely to be an underestimation of adherence since some patients who buy their treatment, may not take it. This could explain some “resistance” described to antiplatelet therapy.

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Cardiovascular disease is associated with an increased risk of chronic obstructive pulmonary disease in a population screened by spirometry

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Purpose: Chronic Obstructive Pulmonary Disease (COPD) is expected to be the third cause of mortality in the world in 2020. Paradoxically, this disease is widely underdiagnosed and its prevalence remains relatively unknown, in particular in people at cardiovascular risk for whom the association with COPD may worsen the prognosis. The aim of this study was to assess COPD prevalence in a population at cardiovascular risk and to analyse determinants of COPD.

Methods: Our study was based on patients referred for cardiovascular check-up to a Preventive Cardiology Clinic in a University Hospital in 2009. Participants answered to questionnaires on socio-economic level, medical history and lifestyle. They completed an extensive physical examination and a spirometry test. COPD prevalence was based on the spirometric classification proposed by the Global Initiative for Chronic Obstructive Lung Disease. Determinants of COPD were assessed with logistic regression.

Results: The sample comprised 502 participants (mean age: 57.4±11.1 years), including 60% of men, 17% of current smokers, 42% of former smokers and 10% of patients with a history of cardiovascular disease (ischemic heart disease, cerebrovascular or peripheral arterial disease). Ten-year risk of coronary heart disease according to the Framingham equation was intermediate (10-20%) for 33% of patients and high (> 20%) for 5%. After exclusion of asthmatic patients, 5.8% [95% CI: 3.9% - 8.2%] were spirometrically classified as COPD patients according to the Global Initiative for Chronic Obstructive Lung Disease. Determinants of COPD were assessed with logistic regression.

Conclusion: Patients with cardiovascular disease are at increased risk of COPD and thus should beneficiate from COPD screening.

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Prevalence of cardiovascular risk factors in coronary patients from the Sahel region of Tunisia

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Introduction: Cardiovascular diseases are the leading cause of mortality in the western countries at the same time they are beginning to appear with increasing frequency in developing countries. With the epidemiological transition phenomenon, Tunisia is now facing the growing prevalence of chronic diseases. The Tunisian epidemiological data on cardiovascular disease in the