CHRONIC VENOUS DISEASE: THROUGH BODY MASS INDEX

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Many studies have confirmed obesity as a Chronic Venous Disease (CVD) risk factor. Few studies have described the pathology through Body Mass Index (BMI). OBJECTIVES: To describe the impact of obesity in CVD. METHODS: Between May and July, 2003, 567 GP's recruited 1049 female patients spontaneously consulting for CVD. The patients filled in a series of validated questionnaires in order to evaluate the consequences of their disease. RESULTS: The results of the study concern 1045 patients with a mean age of 44-45 years old (SD 10.70) (min: 18–max: 65); 66% with a professional activity. The patients average size was 164.39cm (SD 5.99) for an average weight of 65.2kg (SD 12.5). The BMI calculation gives an estimated the 1-year risk of stopping initial treatment, the frequency of patients requiring add-on or switch therapy with other antihpT. OBJECTIVES: A retrospective cohort study was conducted using Health Search Database that provided data by 320 Italian general practitioners. All newly-diagnosed hypertensive patients aged ≥35 years, who received antihypertensive drugs (antiHTN) on morbidity and mortality, the extent of undertreatment and non-persistence is extremely high, hampering their effectiveness in real-life. In order to assess drug utilization patterns of newly treated hypertensive patients, we estimated the 1-year risk of stopping initial treatment, the frequency of patients requiring add-on or switch therapy with other antiHTN. METHODS: A retrospective cohort study was conducted using Health Search Database that provided data by 320 Italian general practitioners. All newly-diagnosed hypertensive patients aged ≥35 years, who received antiHTN during the first three months after diagnosis were identified and were categorized into one of the following groups: 1) Continuers: patients continuing the first class of antiHTN; 2) Combiners: patients receiving an add-on with another class; 3) Switchers: patients changing from the first medication to another type of antiHTN; and 4) Discontinuers: patients stopping the first type therapy. RESULTS: Overall, among 13,303 new hypertensives, 19.8% were continuers, 22.1% combiners, 15.5% switchers, and 42.6% discontinuers. The highest proportion of continuers was found for persons starting with angiotensin-II antagonists (ARB's) (25.2%), calcium-antagonists (CCB's) (23.9%), and ACE-inhibitors (23.3%). Starting on diuretics was associated with the highest risk of discontinuing treatment, while the lowest risk was associated with starting on ARB's (Hazard Ratio [HR]: 0.43; 95% Confidence Interval [CI]: 0.40–0.47), ACE-inhibitors (HR: 0.50; CI: 0.47–0.53) and CCB's (HR: 0.55; CI: 0.52–0.59). The risk of receiving add-on therapy was associated with a longer duration of therapy. Patients starting with alpha-blockers had the highest risk of switching therapy (HR: 0.50; CI: 0.47–0.53), while patients starting on ARB's (HR: 0.51; CI: 0.42–0.62) or ACE-inhibitors (HR: 0.60; CI: 0.52–0.69) had the lowest risk. CONCLUSIONS: In this cohort the persistence to initial antiHTN is rather low and the need to combine several drugs is often required.

TREATMENT OF NEWLY-DIAGNOSED HYPERTENSIVE PATIENTS IN ITALY: A RETROSPECTIVE COHORT STUDY IN PRIMARY CARE


OBJECTIVES: Despite the proven efficacy of antihypertensive drugs (antiHTN), undertreatment and non-persistence is extremely high, hampering their effectiveness in real-life. In order to assess drug utilization patterns of newly treated hypertensive patients, we estimated the 1-year risk of stopping initial treatment, the frequency of patients requiring add-on or switch therapy with other antiHTN. METHODS: A retrospective cohort study was conducted using Health Search Database that provided data by 320 Italian general practitioners. All newly-diagnosed hypertensive patients aged ≥35 years, who received antiHTN during the first three months after diagnosis were identified and were categorized into one of the following groups: 1) Continuers: patients continuing the first class of antiHTN; 2) Combiners: patients receiving an add-on with another class; 3) Switchers: patients changing from the first medication to another type of antiHTN; and 4) Discontinuers: patients stopping the first type antiHTN.