Purpose We assessed the impact of the control of RF at baseline on long-term all-cause and CV mortality in French general population.

Methods Analysis was based on the participants aged 35-64 of the Third French MONICA population-based survey on RF (1995-1996). Vital status was obtained 18 years after inclusion. Statistical analysis was based on multivariable Cox modeling. We assessed the impact of the control (according to the threshold recommended in the guidelines currently used at the time of recruitment) of high blood pressure, high LDL-cholesterol, diabetes and smoking.

Results In our study, 3402 subjects were included. Half were men and 2.5% had history of Coronary Heart Disease. Moreover 569(17%) subjects had 2 or more non-controlled RF, 1194(35%) had 1 non-controlled RF, 770(23%) had all RF controlled under treatment (or were former smokers) and 869(25%) had none RF. During the follow-up, 389 deaths occurred (76 due to a CV cause). Considering all-cause mortality, after adjustment for centre, age, gender, educational level, proxies of alcohol consumption plus medical history of chronic disease, the hazard ratio (HR) for subjects presenting 1 non-controlled RF and for subjects presented 2 or more non-controlled RF was 1.38 [1.03-1.83] (p=0.029) and 1.80 [1.33-2.43] (p<0.001), respectively, as compared to subjects presented all RF controlled. For subjects presented none RF, adjusted HR was 0.66 [0.44-0.98] (p=0.042). Considering CV mortality, adjusted HR for subjects presented 1 non-controlled RF and for subjects presented 2 or more non-controlled RF was 1.70 [0.84-3.42] (p=0.138) and 3.67 [1.85-7.29] (p<0.001), respectively, as compared to subjects presented all RF controlled or none RF.

Conclusions Failing to control RF increases significantly long-term all-cause and cardiovascular mortality.

The author hereby declares no conflict of interest

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0520

Determinants of 3-year mortality after an acute coronary syndrome – the French population MONICA registry

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Background Determinants of short-term mortality after acute coronary syndrome (ACS) are relatively well known. However, those for middle-term mortality aren’t clearly established.

Purpose The aim of our study was to describe 28-day mortality in patients hospitalized for ACS in comparison with the middle-term mortality.

Methods This study was based on data from 6812 people aged 35-74 years hospitalized for a first or a recurrent ACS, registered in the Strasbourg and Toulouse MONICA registry between 2009 and 2011. Three categories of ACS were defined: (ST+), ACS with ST elevation at ECG; (ST-Enz+), ACS with no ST elevation but significant cardiac enzyme elevation; (ST-Enz-), ACS with no ST elevation and no enzyme elevation.

Results The mean follow-up was 3.3±1.1 years with a maximum of 5 years. In all there were 2441 (35.8%) ACS with (ST+), 1548 (22.7%) ACS with (ST-Enz+) and 2823 (41.4%) patients with (ST-Enz-). The 28-day mortality rate was 9.5% [7.1-11.9]. The risk of death at 28-days was (OR [95% CI]) 0.67 [0.51-0.88] for (ST-Enz+) and 2.74 [2.29-3.28] for (ST-Enz-).

Conclusions For STEMI patients risk of death was higher at 28 days and lower when middle-term mortality was considered. These patterns were inverse for NSTEMI (ST-Enz-) patients. In the early years following ACS mortality rate was around 2.9% each year.

The author hereby declares no conflict of interest

0185

Prevalence of conventional risk factors in 44154 Tunisians patients with coronary heart disease

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Introduction The prevalence of the major conventional cardiovascular risk factors (cigarette smoking, diabetes mellitus, hypertension, and dyslipidemia) among coronary heart disease (CHD) patients in Tunisia has not been studied extensively. The aim of this study was to evaluate the frequency of cardiovascular risk factors and their association in patients hospitalised for coronary heart disease at Rabta, Charles Nicolle, Habib Thameur, Military Hospitals (Tunis), Fattouma Bourguiba hospital (Monastir), Farhat Hached, and Sahoul hospitals (Sousse); Mohamed Tahar Maamouri Hospital (Nabeul); Menzel Bourguiba Hospital and Ibn El Jazzar Hospital (Kairouan) over the period 1994-1998 and during 2004.

Methods The clinical features of 44154 patients (25635 men (58.1%) and 18519 women (41.1%) on hospital admission were analyzed.

Results 40.8% of the patients were hospitalized for coronary deficiency, 16.5% for valvular cardiopathy, 4.8% for cardiomiophathy, 16.9% for arrhythmia and conduction disturbance, 3.6% for essential hypertension, 2.5% for stroke and 14.9% for various pathologies.

The prevalence of hypertension, diabetes, smoking, obesity and dyslipidemia was 29.9%, 30.3%, 66.9%, 11.9%, and 30.2% respectively in the men and 43.5%, 30.2%, 3.5%, 14.6%, and 27.1% respectively in women.

Conclusion With this risk factor profile Tunisia has to implement a national strategy of primary prevention and heart health promotion in addition to the efforts recently made in secondary prevention of some chronic disease such as hypertension, diabetes, and smoking.

The author hereby declares no conflict of interest

0086

Does leisure physical activity efficiently decrease the consequences of occupational social inequalities on cardiovascular diseases? Prime study

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Introduction Regular leisure physical activity is encouraged to reduce the risk of cardiovascular disease (CVD) and mortality, but the observance of this guideline is not perfect. In parallel, the consequences of occupational-social inequalities on CVD have been well-described and persist.

Objective To assess the potential mediating effect of leisure physical activity on the consequences of occupational status on CVD.

Method 5683 French employed men were recruited from the cohort Prime study. Employees and manual workers were compared with white collar (chef of enterprise, intermediate staff). Hard CVD, myocardial infarction, angora, coronary death, total heart events and stroke were investigated over a 10 years follow-up. Leisure physical activity was measured using compendium physical activity. Cox analyses were used for analyzing the consequences of social inequalities on each event adjusted for classical cardiovascular risks. The propor-
tion of effect was calculated to explain the potential mediating effect of leisure physical activity on the relationship between occupational social categories and CVD.

Results The incidence rates were respectively for: Hard CVD (2.4%), myocardial infarction (2.2%), angina (3.4%), coronary death (0.4%), total heart events (5.7%) and stroke (1.1%). Employees and manual workers have significant higher risks of hard cardiovascular events, myocardial infarction and total heart events compared with white collar, in crude analysis (HR≈1.5). Adjustments for classical cardiovascular factors reduced significantly these risks while a weak impact of leisure physical activity on the relationships between occupational categories and each event was highlighted.

Conclusion The cardiovascular gradient observed between the different occupational categories is mainly explained by classical cardiovascular factors. Leisure physical activity is not sufficient by itself to compensate the occupational social inequalities.

The author hereby declares no conflict of interest

0235

Incidence of sudden cardiac death in sub-Saharan Africa: the Douala-SCD registry

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Background A population-based incidence estimates of Sudden Cardiac Death (SCD) in sub-Saharan Africa (SSA) is unknown. We sought to determine the epidemiology of SCD in Douala, Cameroon.

Method and results During 12 months, 4 districts were randomly chosen and monitored to monitor all deaths. The COSA (“comité de santé”) of each area registered every death, and a postgraduate fellow recorded detailed demographic and medical data for victims of natural death. A senior physician studied each case of suspected sudden death, either cardiac or extra-cardiac. For optimal exhaustiveness, surrounding hospital mortuaries were checked simultaneously to match identities of victims. Established SCD was defined as rapid witnessed collapses leading to death within 1h after the onset of symptoms, and probable SCD as unexpected death within 24h without obvious extra-cardiac cause. Our registry numbered 240 000 people and 2304 deaths. The overall mortality rate was 11.2/1000 inhabitants/year. Four (0.3%) were sudden extra-cardiac death, and 58 (2.5%) SCD of which 41.4% were established and 7.4% of victims experienced cardiopulmonary resuscitation attempts.

Conclusion Although not negligible, the SCD incidence in this SSA population is lower than that reported in most of western countries. However, as the vast majority of cases are witnessed cardiac arrests, the absence of CPR attempts raises the question of educating populations in basic life support rescue to tackle this potential reversible fatal outcome.

The author hereby declares no conflict of interest

0214

Classifying heart failure patients to describe outpatient and inpatient care pathways in the French region Languedoc-Roussillon. First results of the cohort named “CarPathes”

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Introduction Care pathways are quickly developing involving hospital and out-of hospital cares for patients with heart failure (HF). To improve the clinical management and optimize the insurance economics, we aimed at describing the care pathways and the consistency with clinical status and care access.

Methods A retrospective cohort of patients living in the French region Languedoc-Roussillon was built. Inclusion criteria were mainly: first admission for HF in 2012; follow-up more than 1 year. The database we used (the SNIIRAM) include outpatient care claim data and hospitalization data. Patients were classified by a hierarchical ascending classification on principal components, using variables describing clinical status, use of specialized and non-specialized care, and main clinical outcomes (hospitalization, death).

Results 2751 patients were included and followed during a median of 22 months. Mean age was 78, 484 (18%) died, 818 (30%) were readmitted at least once for heart failure. The cluster analysis revealed three different significant groups: 1/ group 1 (N=734) is characterized by a younger age, more cares with cardiologists and less main clinical outcomes. Groups 2 and 3 are not different as regards age and comorbidities. 2/group 2 (N=1060) differs from the group 3 (N=957): less cares out-of the hospital contrasting with more cares at hospital, especially at emergencies.

Conclusion This cohort enables to evaluate consistency and adequation between cares and clinical status, following mail clinical outcomes. As this cohort is built in a heterogeneous region in terms of medical density or health organization, it should be a powerful tool for the study of spatial determinants.

The author hereby declares no conflict of interest

0490

Prasugrel use in “real life”: report from outpatient settings in France

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Objective of the study is to provide descriptive statistics on patterns of prasugrel usage in outpatient settings in France. The aim was to observe if the guidance for the use of Prasugrel from the European label was respected.

Methods This retrospective study was conducted to describe treatment patterns of prasugrel in outpatient settings in France using the IMS Disease Analyzer database, which collects electronic medical records of patients followed by a national representative of 1200 French general practitioners (GPs). Anonymous data are collected prospectively and continuously during each follow-up visit. The study population consisted of patients who had at least 1 prescription of prasugrel in outsetting starting from launch to 3 years post launch. The patients were followed from the date of the first prasugrel prescription recorded in the data base (index date) until they died, changed of GP or reached the end of the study, whichever came first.

Results In France, the IMS Disease Analyzer included 1.052 patients receiving at least one prescription of prasugrel from January 2010 until October 2012. 85% (n=894) were male (n=894), the mean age was 58.5 years. 5.7% of patients were aged more than 75 years, and 5.0% weighed 60kg or less. Only 0.2% (n=2) had a history of TIA/stroke among this cohort.

Prasugrel was prescribed at a daily maintenance dose of 10mg for 99.8% of patients (1.050 patients). Concomitant medications were usual aspirin, lipid lowering agents, beta blockers, angiotensin-converting enzyme (ACE)-inhibitors. 55.1% of patients received an anti-uler medication (mainly Proton Pump Inhibitor [PPI]). The persistence with prasugrel using the MPR (Medication Possession Ratio) was respectively 60.7% and 63.2% for patients with at least 60 days of treatment in previous year and 12 months follow-up (n=213). 13.7% of patients were switched from another tiopridamide (primarily clopidogrel).

Conclusion In prasugrel-treated patients, respect of Prasugrel indications was highly fulfilled. Almost all patients received aspirin combined to prasugrel. Of note, half of patients were treated with an anti-uler medication. The main results reflect a good usage of prasugrel by French GPs, in collaboration with cardiologists, with a satisfying understanding and implementation of the European label, in contrast with recent American registry’s findings.

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