



Correlation between perceived cardiovascular risk (CVR) by physicians and real CVR is poorly known. Moreover, the underlying question of factors associated to risk misevaluation, especially for patients at high CVR and that could benefit of a lipid lowering therapy (LLT), remains unsolved.

Objective and methodology: This was an on-line non-interventional study conducted on a sample of 619 general practitioners. The aim was to describe the relation between physicians evaluated CVR and calculated CVR according to risk's scales. All consulting patients' aged 50 years old (YO) were included. Physicians had to complete a questionnaire and to assess patient's CVR on a 3 level scale (low, medium, and high). Framingham and SCORE (low risk <2%, high risk 5%) were calculated.

Results: 13446 patients were included (mean age: 67 YO, male: 48%, LDLc 1.3g/L: 46%, LLT: 36%, personal history of CV disease: 16%, smoker: 12%, high blood pressure (HBP): 52%, diabetes: 18%).

Population risk is listed below

	Evaluated (%)	Framingham (%)	Score (%)
Low	40	41	28
Medium	37	24	24
High	23	35	48

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.

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.

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

	OR	CI 95%
Treated HBP vs no HBP	2,55	2,04-3,19
Gender (male)	2,44	2,16-2,76
Higher LDLc	2,13	1,78-2,55
Smoker	1,82	1,52-2,19
Chronic inflammatory disease	1,19	1,00-1,42
Age	1,16	1,15-1,17

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Determinants of aortic stiffness in HIV-infected patients

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Objective: Human immunodeficiency virus (HIV)-infected patients receiving combined active antiretroviral therapy (cART) are at higher risk of cardiovascular disease, due in part to metabolic complications such as lipodystrophy syndrome, insulin resistance, and dyslipidemia. Whether lipodystrophy and cART impact on the vasculature is debated. We investigated the impact of lipodystrophy and protease inhibitors (PIs) on aortic stiffness.

Methods: Aortic stiffness was evaluated using carotid-femoral pulse wave velocity (PWV) in consecutive HIV-infected patients without a history of cardiovascular disease referred to a cardiovascular clinic.

Results: 175 patients were enrolled (mean age 48.2 ± 8.7 years; 89% men). Eighty six per cent of patients were receiving cART. Dyslipidemia, tobacco, and hypertension were the most prevalent cardiovascular risk factors (39%, 38%, and 31%, respectively). Seventy-nine (45%) HIV-infected patients had lipodystrophy and 80 (46%) were on PIs. Aortic PWV was similar in patients with or without lipodystrophy (9.7 ± 1.9 vs 9.8 ± 2.5 ms^{-1} , respectively; $P = 0.81$) and in patients on or not on PIs (9.8 ± 2.6 vs 9.7 ± 1.9 ms^{-1} ; $P = 0.71$). In univariate analysis, aortic PWV was associated with increasing age, waist/hip ratio, systolic and diastolic blood pressures, mean arterial and pulse pressures, but not with presence of lipodystrophy, PIs, or specific factors related to HIV infection. Linear regression analysis showed an association between aortic PWV and age ($= 0.49$, $P = 0.001$) and systolic arterial pressure ($= 0.21$, $P = 0.006$).

Conclusions: Aortic stiffness is associated with traditional cardiovascular risk factors, particularly ageing and blood pressure. Hypertension is becoming an emerging complication in HIV-infected patients.

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Blood pressure in HIV-infected patients

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Objective: To determine the prevalence of hypertension in a cohort of HIV-infected patients (HIV+).

Methods: HIV+ patients were enrolled consecutively at ambulatory cardiology consultation. We evaluated:

- cardiovascular risk factors,
- office blood pressure,

24 hours ambulatory blood pressure monitoring (ABPM).

We identified patients with known hypertension, masked hypertension and white-coat effect.

Results: 258 HIV+ patients (mean age 49 ± 7 ans, 91% men) were consecutively included in this study between 2005 and 2009. Cardiovascular risk factors were as follows: 52% had dyslipidemia, 51% were active smokers, 40% with known hypertension and 9 % were diabetics. Body mass index of the entire cohort was 24 ± 4 kg/m 2 and 89% were under antiretrovirals. Data on blood pressure are depicted in Table 1. 19% (29) were discovered to have hypertension.

Conclusion: Hypertension is frequent in HIV-infected patients and more and more common with aging. The number of non-dipper HIV+ was high in this cohort. Studies on the impact of HIV infection and antiretrovirals on the autonomic nervous system should be performed.

Parameters	N= 258
Office systolic BP, mmHg	131 \pm 19
Office diastolic BP, mmHg	81 \pm 10
Mean 24h-systolic BP, mmHg	125 \pm 13
Mean 24-diastolic BP, mmHg	77 \pm 9
Daytime systolic BP, mmHg	129 \pm 13
Daytime diastolic BP, mmHg	80 \pm 9
Nighttime systolic BP, mmHg	115 \pm 17
Nighttime diastolic BP, mmHg	68 \pm 10
BP profile in known hypertensive patients	N= 103
Number of patients with appropriate BP control, %	45%
Number of patients with white-coat effect, %	17%
Non dipper, %	43% in known hypertensive patients 39% in unknown hypertensive patients

January 14th, Friday 2011

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Screening for abdominal aortic aneurysm among patients admitted for acute myocardial infarction using portable transthoracic echocardiography.

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Background: Abdominal aortic aneurysm (AAA) remains asymptomatic for many years but often revealed dramatically (inaugural rupture). Its relatively low prevalence in the general population (5.5% of men over 65 years) implies specific target population screening. Patients with acute myocardial infarction (AMI) represent a high-risk population in which screening for other atherosclerotic locations is recommended but is still often neglected. We aimed to evaluate the feasibility of AAA screening during routine transthoracic echocardiography (TTE) in patients with AMI using a portable echocardiography system and to determine the prevalence of AAA in this population.

Methods: We prospectively measured the size of the abdominal aorta at the end of a regular TTE performed at bedside in consecutive patients admitted for AMI in our intensive care unit using a portable TTE system (Vivid, General electric). AAA was defined by a transverse diameter ≥ 30 mm.

Results: One hundred and fifty two patients were enrolled (mean age 65 ± 14 years old, 78% of male). Measurement of the size of the abdominal aorta was feasible in 93% (10 patients had poor echogenicity) and time duration was 3 ± 1 min. Interobserver variability between cardiologists was good (1.7 ± 1 mm). Eight patients had an AAA (5.2%) and prevalence increases with

age, 8.7 % after 60 years, 10.3% after 65 years. No patient below 50 years old had an AAA.

Conclusion: In patients admitted for AMI, screening for AAA during TTE using a portable TTE system was fast and highly feasible. Despite a striking low prevalence of AAA in this high cardiovascular risk population, analyse of the abdominal aorta should be recommended during TTE ("one cardiovascular shot") especially in elderly patients in regard to the simplicity, incoercity and availability of the present screening.

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Prevalence and risk factors of lower extremity artery disease in subjects without traditional modifiable cardiovascular risk factors. The multi-ethnic study of atherosclerosis.

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Introduction: Lower-extremity peripheral artery disease (PAD) is associated with traditional cardiovascular disease risk factors (smoking, hypertension, dyslipidemia, diabetes). Among participants in the Multi-Ethnic Study of Atherosclerosis (MESA), we sought to assess the prevalence of PAD in a population without these risk factors. We hypothesized that this prevalence is not negligible, and that in this situation, PAD would still remain associated with other measures of subclinical atherosclerosis.

Methods: In the MESA cohort, we selected those (n=1932) meeting the following criteria: no smoking over the last 10 years, no history of hypertension, dyslipidemia or diabetes, and normal blood pressure (140/90), fasting blood glucose 1.26 g/l, and a total-/HDL-cholesterol ratio < 5 . Participants were classified according to their ankle-brachial index (ABI) into 3 groups: low (< 1.00), normal (1.00-1.30) and high (> 1.30) ABI. Measures of subclinical atherosclerosis included any coronary artery calcification (CAC) or carotid plaque.

Results: Overall, the mean estimated Framingham risk score for coronary heart disease was 0.61% /year. Low- and high ABI were found in 176 (9%) and 149 (7.8%) participants, respectively. In multivariable models including age, gender and ethnicity, lower glomerular filtration rates (OR: 0.88 /10 units, $p=0.04$) and higher interleukin-6 levels (OR:1.42 /natural-log unit, $p=0.02$) were associated with low ABI. Higher body-mass index (OR:1.07 /unit, $p<0.001$) was associated with high ABI. In a fully-adjusted model, low-ABI, not high-ABI, was significantly associated with CAC prevalence (OR:1.22, $p<0.03$). No significant association was found with carotid plaque.

Conclusion: In subjects without traditional risk factors, PAD is common. Such persons remain at higher risk for coronary artery disease.

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Prognosis interest of ambulatory blood pressure monitoring in chronic heart failure: preliminary descriptive analysis.

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Background: Ambulatory blood pressure monitoring (ABPM), while used routinely in Hypertension, has rarely been applied in Chronic Heart Failure (CHF). This study was designed to assess prognostic value of ABPM data in our patients with CHF.