IS RISK FACTOR CONTROL AND EVIDENCE BASED MEDICAL THERAPY SIMILAR IN NON OBSTRUCTIVE AND OBSTRUCTIVE CORONARY ARTERY DISEASE (CAD) PATIENTS: A VETERANS AFFAIRS RETROSPECTIVE STUDY.

ACC Poster Contributions
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Background: Aggressive risk factor control and evidence based medical therapy is recommended for coronary artery disease (CAD) patients (pts). While it is thought that obstructive CAD (OCAD) pts may achieve such targets, data in non obstructive (NOCAD) CAD pts is lacking. We wished to see whether physicians were more aggressive treating patients with OCAD than NOCAD.

Methods: Pts undergoing coronary angiography that showed OCAD or NOCAD, between Jan 2006- Jun 2009 at the Oklahoma City VA Medical Center and where 1 year follow-up data was available were included. Demographic, clinical and laboratory data were compared between OCAD & NOCAD groups at baseline and 1 yr. Non-parametric Wilcoxon Sum rank test was used to compare means and chi-square tests for proportions, at a significance level of 0.05.

Results: A total of 354 pts were eligible of which 222 (63%) had follow up data available at 1 year. Mean age in OCAD group was 62± 7 yrs vs. 63±8 yrs in NOCAD group (p=NS). >95 % were males in both groups. At baseline the obstructive (N=103) and non obstructive groups (N=119), differed in hypertension (91 vs. 81%) and heart failure (28 vs. 17%) (p<0.05). The use of aspirin and statins were significantly lower in NOCAD group both at baseline and 1 year. Among OCAD group the use of beta blockers, statins and angiotensin converting enzyme inhibitors (ACEI) were better at 1 yr compared to baseline (P<0.05) and systolic blood pressure(SBP), triglycerides, and serum creatinine were better. Among NOCAD group there were no significant differences at the end of 1 year. The use of aspirin, beta blockers, statins and ACEI was higher in the OCAD group at 1 year. Among OCAD and NOCAD groups, 57% and 71% were at target LDL level of ≤100 at 1 year (compared to 57% and 61% at baseline) respectively.

Conclusion: The use of evidence based medical therapy is less than ideal regardless of the extent of CAD. This is more evident in NOCAD group suggesting physicians are less aggressive in treating these patients. Better strategies for risk factor control and use of evidence based medical therapy will be required to achieve the desirable goal. Long term data is needed to quantify clinical impact of these differences in treatment.