effects other than bleeding and thrombosis (38.5% vs. 16.7%, p = 0.004). Patients on TSOAC had a lower [better] mean Qol. summary score compared to warfarin treated patients (39.5 ± 11.3 vs. 46.8 ± 19.8, p = 0.03). Based on the results of the unadjusted linear regression model, patients treated with TSOAC had significantly better QASS DQ summary score (β = 7.85, 95% CI: −13.49, 1.82, p < 0.05), however, after adjusting for differences in patient groups, the effect of TSOAC on Qol became non-significant (β = 4.47, 95% CI: −5.06, 14.00, p = 0.30). CONCLUSIONS: Differences in social-demographic characteristics between patients treated with warfarin and TSOAC were observed in a different population. After adjusting for patient social-demographic characteristics, TSOAC had no impact on treatment-related Qol.

PCV108
PRELIMINARY VERIFICATION OF THE DIAGNOSTIC ACCURACY OF THE SYNDROME DIFFERENTIATION QUESTIONNAIRE OF PHLEGM AND BLOOD STASIS (SDQ-PBS)

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OBJECTIVES: SDQ-PBS was a validated and reliable diagnostic instrument for syndrome of PBS of angina patients. For well reception and wide application, it was important and necessary to verify the diagnostic accuracy of the syndrome dimension of the questionnaire before applications. METHODS: The Fisher’s discriminant model was established for syndrome of PBS dimension to determine weights of items. Angina patients (40-85 years old) diagnosed by coronary angiography or coronary computed tomography were selected to compare and verify the SDQ-PBS syndrome of PBS (any syndrome others) were diagnosed by 3 traditional Chinese medicine physicians. According to the Canadian Cardiovascular Society Classification (CCSC), subjects of PBS were divided into mild and severe degree. Final scores were calculated combining initial scores and weights of items. The diagnostic accuracy was preliminarily verified by comparison of final scores and diagnostic threshold. RESULTS: The final score of Fisher’s discriminant model = 1.406 × body mass index + 0.913 × purple lips + 0.845 × poor appetite + 0.605 x glomus and fullness + 0.436 x slimness in mouth –6.426. There were 44 subjects (age: 69.12±9.26, sex: male,36.36%) involved and 35 were diagnosed PBS, 9 non-PBS. According to CCSC, most patients were mild degree and 16 severe. Through the comparison of final scores and diagnostic threshold (8.5), 34 of 35 PBS subjects were diagnosed as syndrome of PBS, the diagnostic accuracy of the syndrome dimension was 97.14%. Of 9 non-PBS subjects, 1 was diagnosed PBS, the diagnostic accuracy was 88.89%. For subjects of mild and severe degree, 18 and 16 were diagnosed PBS respectively, the diagnostic accuracy were 94.73% and 100%. CONCLUSIONS: The diagnostic accuracy of the syndrome dimension of the questionnaire was high. For different degree of patients, the treatment strategy was more different. In the future, more study will be conducted to further verify the diagnostic accuracy of the questionnaire.

CARDIOVASCULAR DISORDERS – Health Care Use & Policy Studies

PCV109
A SYSTEMATIC REVIEW, CRITICAL APPRAISAL AND ANALYSIS OF THE QUALITY OF ECONOMIC EVALUATIONS IN STROKE IMAGING


OBJECTIVES: To explore the reasons for not initiating or stopping VKA treatment in patients with atrial fibrillation (AF) at moderate to high risk of stroke, along with the reasons for considering some patients on VKA to be “difficult-to-manage”. METHODS: A retrospective review was conducted of 29 Swedish physicians participating Three cohorts of AF patients at moderate/high stroke risk (CHADS2 score ≥ 2 points) were examined: a) VKA naive, b) had stopped VKA treatment or c) receiving VKA and considered “difficult-to-manage”. Variables retrieved were: socio-demographic characteristics of AF, VKA treatment and its management and the reasons why patients a) never received VKA, b) stopped VKA, or c) were considered “difficult-to-manage”. RESULTS: In Canada, 187 patients received VKA naive/stopped/vka, 58.3% males, mean (SD) age 78.4 (9.9) years. In Sweden, 152 patients were included (naive/stopped/difficult-to-manage/39/24/89), 68.4% males, mean (SD) age 76.0 (8.8) years. For VKA naive patients, the most common reasons for not initiating VKAs were: Canada – transients nature of AF (63.3%), fall risk (30.6%); Sweden - patient refusal to take VKAs (28.2%), fall risk (1.8%), bleeding risk (1.8%). For patients who stopped VKA treatment, the most common reasons for discontinuation were: Canada – bleeding event (23.8%), patients not willing to comply with treatment regimen (16.9%); Sweden – clinical event (18.2%). For patients on VKA the most common reasons for being considered “difficult-to-manage” were: Canada – concomitant chronic diseases (55.4%), poor INR control (54.2%); Sweden – difficulties in following dietary/ medical advice (24.7%), concomitant chronic diseases (22.5%). CONCLUSIONS: In Canada and Sweden the reasons for not initiating or stopping VKA treatment in AF patients were similar, with fall risk and bleeding events being commonly cited. The main reasons for considering a patient on VKA as “difficult-to-manage” are mainly related to concomitant diseases in both countries.

PCV111
PHYSIOLOGICAL PARAMETERS CAN HELP GUIDE HEART FAILURE THERAPY

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OBJECTIVES: Patients with heart failure leads to significant morbidity and mortality. New pharmacotherapeutic interventions based on the patients heart rate have been incorporated into treatment algorithms, and may lead to improved clinical outcomes. We aimed to assess the impact of the physiological parameters of heart rate on clinical outcomes in patients with chronic heart failure (CHF) through the comparison of CHF patients with chronic heart failure receiving either a beta blocker (BB) or metoprolol succinate (MPS), and its management and the reasons why patients a) never received VKA, b) stopped VKA, or c) receiving VKA and considered “difficult-to-manage”. Variables retrieved were: socio-demographic characteristics of AF, VKA treatment and its management and the reasons why patients a) never received VKA, b) stopped VKA, or c) were considered “difficult-to-manage”. RESULTS: In Canada, 187 patients received VKA naive/stopped/vka, 58.3% males, mean (SD) age 78.4 (9.9) years. In Sweden, 152 patients were included (naive/stopped/difficult-to-manage/39/24/89), 68.4% males, mean (SD) age 76.0 (8.8) years. For VKA naive patients, the most common reasons for not initiating VKAs were: Canada – transients nature of AF (63.3%), fall risk (30.6%); Sweden - patient refusal to take VKAs (28.2%), fall risk (1.8%), bleeding risk (1.8%). For patients who stopped VKA treatment, the most common reasons for discontinuation were: Canada – bleeding event (23.8%), patients not willing to comply with treatment regimen (16.9%); Sweden – clinical event (18.2%). For patients on VKA the most common reasons for being considered “difficult-to-manage” were: Canada – concomitant chronic diseases (55.4%), poor INR control (54.2%); Sweden – difficulties in following dietary/ medical advice (24.7%), concomitant chronic diseases (22.5%). CONCLUSIONS: In Canada and Sweden the reasons for not initiating or stopping VKA treatment in AF patients were similar, with fall risk and bleeding events being commonly cited. The main reasons for considering a patient on VKA as “difficult-to-manage” are mainly related to concomitant diseases in both countries.

PCV112
PERSONAL CARDIOVASCULAR HEALTH RISK ASSESSMENT AND MANAGEMENT IN THE WORKPLACE: A PILOT PROGRAM

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OBJECTIVES: To set up a model for effective workplace health management as an occupational health service for employees of a steel factory in southern Taiwan. METHODS: In compliance with the administrative regulation of the company’s policy, 51 male employees with persistent blood pressure (BP) higher than 160/100 mmHg, and 23 male employees with persistent fasting blood sugar (FS) higher than 200 mg/dl during the last three consecutive annual employee health examination were identified through a process of cardiovascular risk assessment, and recruited into a health management program, which consisted of health education for diet control and regular exercise, mandatory weekly BP or postprandial blood sugar (PC) monitoring at company medical office for 3 months, and subject was required to submit proof of physician visit and drug treatment if the subject was noted to have BP higher than 140/90 mmHg or PC higher than 200 mg/dl in two consecutive measurements. Outcome evaluation was analyzed with descriptive statistical analysis. RESULTS: At the end of the study period, the number of hypertensive subjects decreased from 161 mmHg to 145 mmHg, diastolic BP from 104 mmHg to 94 mmHg, and 7 of them achieved satisfactory BP control under 120/80 mmHg. Among PC among all the subjects, the level of FS was reduced from 301 mg/dl to 240 mg/dl, and 5 of them achieved satisfactory PC control under 140 mg/dl. Out of the 46 subjects who filled out the program satisfaction survey, 97.8% were satisfied with the dietary control component of the health education course, 93.5% were satisfied with the exercise component, 97.8% were satisfied with weekly BP or PC measurements, and 58.7% would recommend the same program to their colleagues in the future. CONCLUSIONS: Company management policy is a key element in the success of workplace health management for the control of chronic diseases with high cardiovascular risk such as hypertension and diabetes.