

The Risk of Fracture Following Hospitalization in Older Women and Men

Hospitalization occurs commonly among elderly persons, can cause loss of bone and muscle strength, and may be a marker for impaired physical function that may increase the risk of fracture. Gardner et al prospectively studied 3075 elderly men and women, with a mean 6.6 years of follow-up, and found that, after adjusting for age, sex, and race, subjects with any hospitalization had a 2-fold increased risk of hip and other fractures compared with those who were not admitted to a hospital. Two hospitalizations indicated a 2.42-fold increased risk of hip fracture (95% confidence interval, 1.19-4.90), and 3 indicated a 3.66-fold increased risk of hip fracture (95% confidence interval, 1.97-6.81). Among elderly persons, hospitalization is a very common and strong risk factor for fracture and also an opportunity to take measures to reduce the risk of fractures.

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Long-term Clinical Outcomes Following Coronary Stenting

Anstrom et al compare the long-term clinical outcomes of patients receiving drug-eluting stents (DES) vs bare metal stents (BMS) in a clinical practice setting. The study population included 1501 patients who received DES and 3165 who received BMS. After adjustment, DES reduced target vessel revascularization (TVR) rates at 6, 12, and 24 months compared with BMS (24-month rates, 6.6% for DES and 16.3% for BMS). The TVR benefit for DES increased among patients with multivessel CAD (1-vessel CAD, 8.3% lower for DES; 2-vessel CAD, 9.7% lower for DES; and 3-vessel CAD, 16.2% lower for DES). Patients receiving DES vs BMS in a clinical practice setting have lower TVR rates, albeit with less absolute benefit than that observed in clinical trials. Patients with multivessel vs single-vessel disease experience a greater reduction in TVR.

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Identification and Characterization of Metabolically Benign Obesity in Humans

Although overall obesity delineates an important risk factor for type 2 diabetes mellitus and cardiovascular disease, body fat distribution additionally represents an independent determinant. For any given amount of total body fat, individuals with excess intra-abdominal (visceral) adipose tissue are at substantially higher risk of being insulin resistant and having a high cardiovascular risk profile. Conversely, even in obesity a metabolically benign obesity may exist. Stefan et al investigated whether such a phenotype can be identified and studied potential mechanisms involved in its generation. Having studied more than 300 subjects using magnetic resonance techniques for measurements of body fat distribution and ectopic fat accumulation as well as for metabolic traits, they identified individuals who are characterized by such a metabolically benign obesity in terms of low insulin resistance and intima-media thickness of the common carotid artery. The most important determinant of this phenotype was less fat accumulation in the liver.

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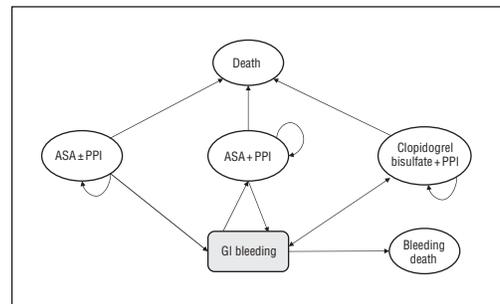
The Obese Without Cardiometabolic Risk Factor Clustering and the Normal Weight With Cardiometabolic Risk Factor Clustering

This study presents nationally representative data regarding the prevalence and demographic correlates of body size phenotypes in the US adult population using the National Health and Nutrition Examination Surveys. Results indicated that among US adults 20 years or older, a high proportion of normal-weight adults were metabolically abnormal, while an even higher proportion of overweight and obese adults were metabolically healthy. The independent correlates of the metabolically abnormal phenotype among normal-weight individuals were older age, lower physical activity levels, and larger waist circumference. The independent correlates of the metabolically healthy phenotype among overweight and obese individuals were younger age, non-Hispanic black race/ethnicity, higher physical activity levels, and smaller waist circumference.

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Cost-effectiveness of Proton Pump Inhibitor Cotherapy in Patients Taking Long-term, Low-Dose Aspirin for Secondary Cardiovascular Prevention

Patients using long-term, low-dose aspirin (ASA) are at increased risk for upper gastrointestinal tract (GI) bleeding. This adverse event can be mitigated through proton pump inhibitor (PPI) cotherapy. However, it is not known if cotherapy is cost-effective in patients at average risk of upper GI bleeding using ASA for secondary cardioprevention. Using a Markov cohort model, Saini et al found that PPI cotherapy is cost-effective in average-risk patients, provided that PPIs are available at over-the-counter cost. At prescription cost, PPI cotherapy is cost-effective only in patients at increased risk for upper GI bleeding, such as those with a history of peptic ulcer disease.



Basic Markov model structure. Ovals represent Markov states; gastrointestinal (GI) bleeding is a discrete event that can occur in any living Markov state; "ASA + PPI" and "clopidogrel bisulfate + PPI" represent high-risk bleeding states (owing to history of bleeding). ASA indicates aspirin; PPI, proton pump inhibitor.

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