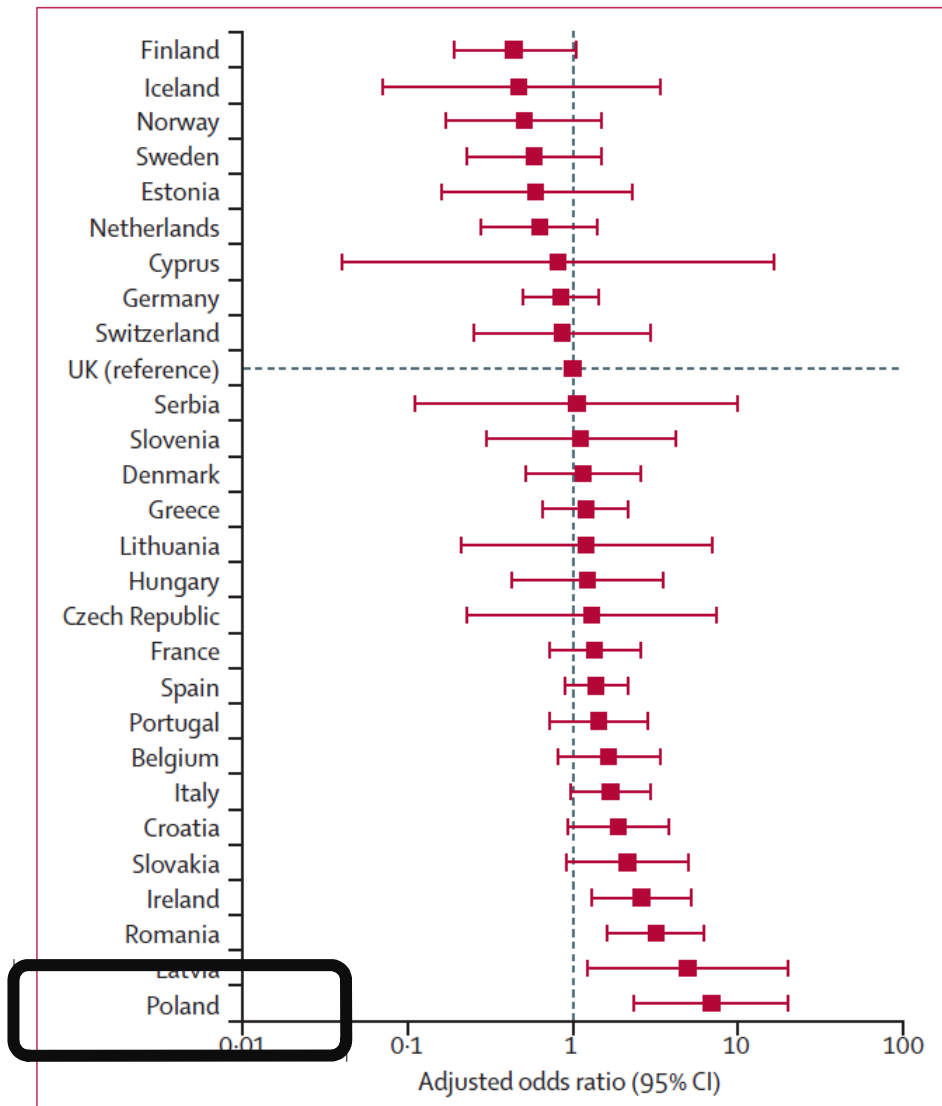
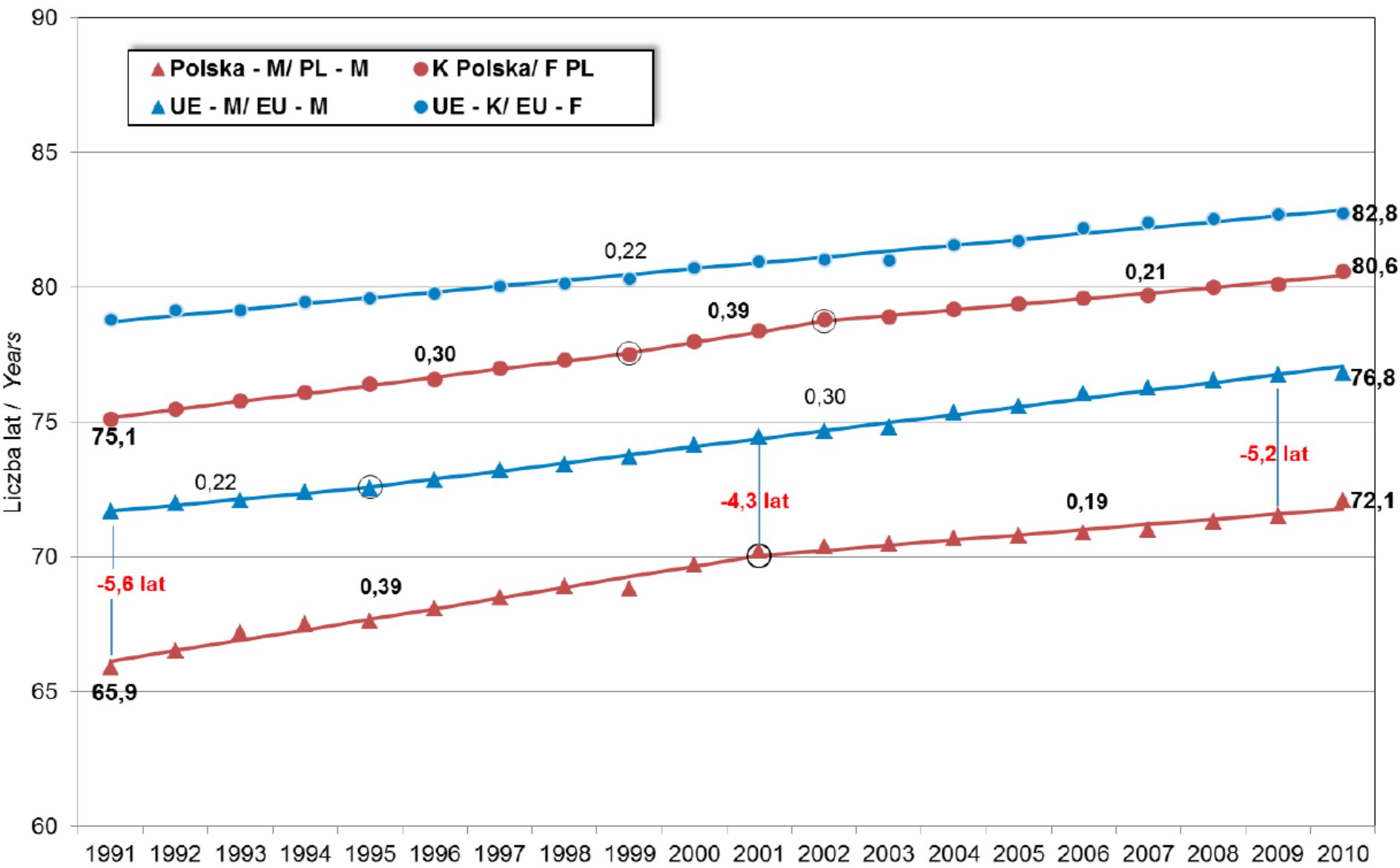


# Adjusted odds ratio for death in hospital after surgery for each country

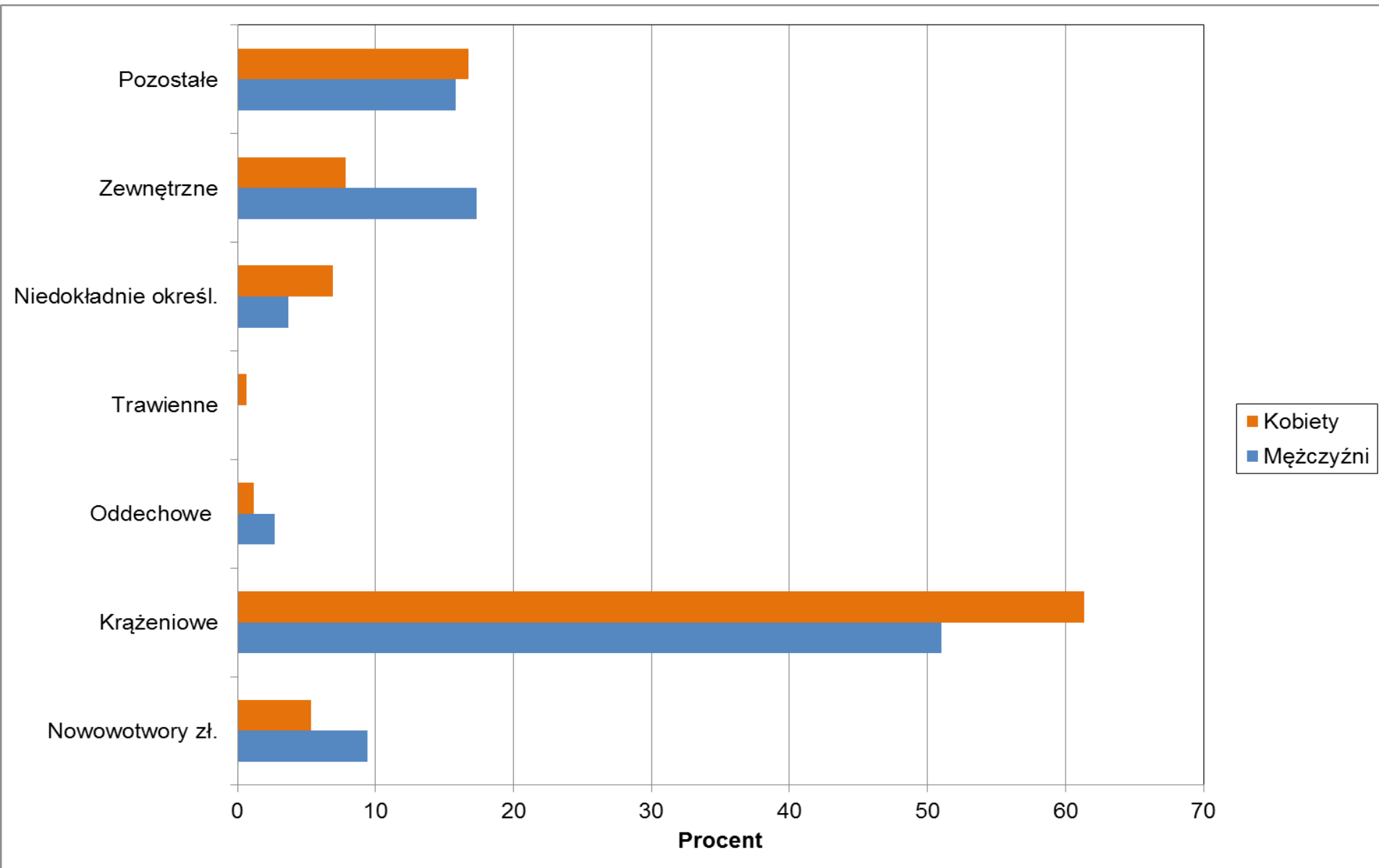


**Przeciętne trwanie życia w wieku 0 lat mężczyzn (M) i kobiet (K) w Polsce oraz średnie dla krajów UE27 w latach 1991–2010 – jego trendy oraz średnioroczne tempo wzrostu (dane GUS, WHO oraz obliczenia własne) / Males (M) and females (F) life expectancy at birth in Poland and average for EU27 countries in years 1991–2010 – its trends and mean annual increase (WHO HFA DB, CSO data and author's own calculations)**



# W jakim stopniu redukcja umieralności z poszczególnych przyczyn wydłużyła długość życia Polaków w latach 1991-2010

Wojtyński B i wsp., NIZP-PZH



Bogdan Wojtyniak

Narodowy Instytut Zdrowia Publicznego - PZH

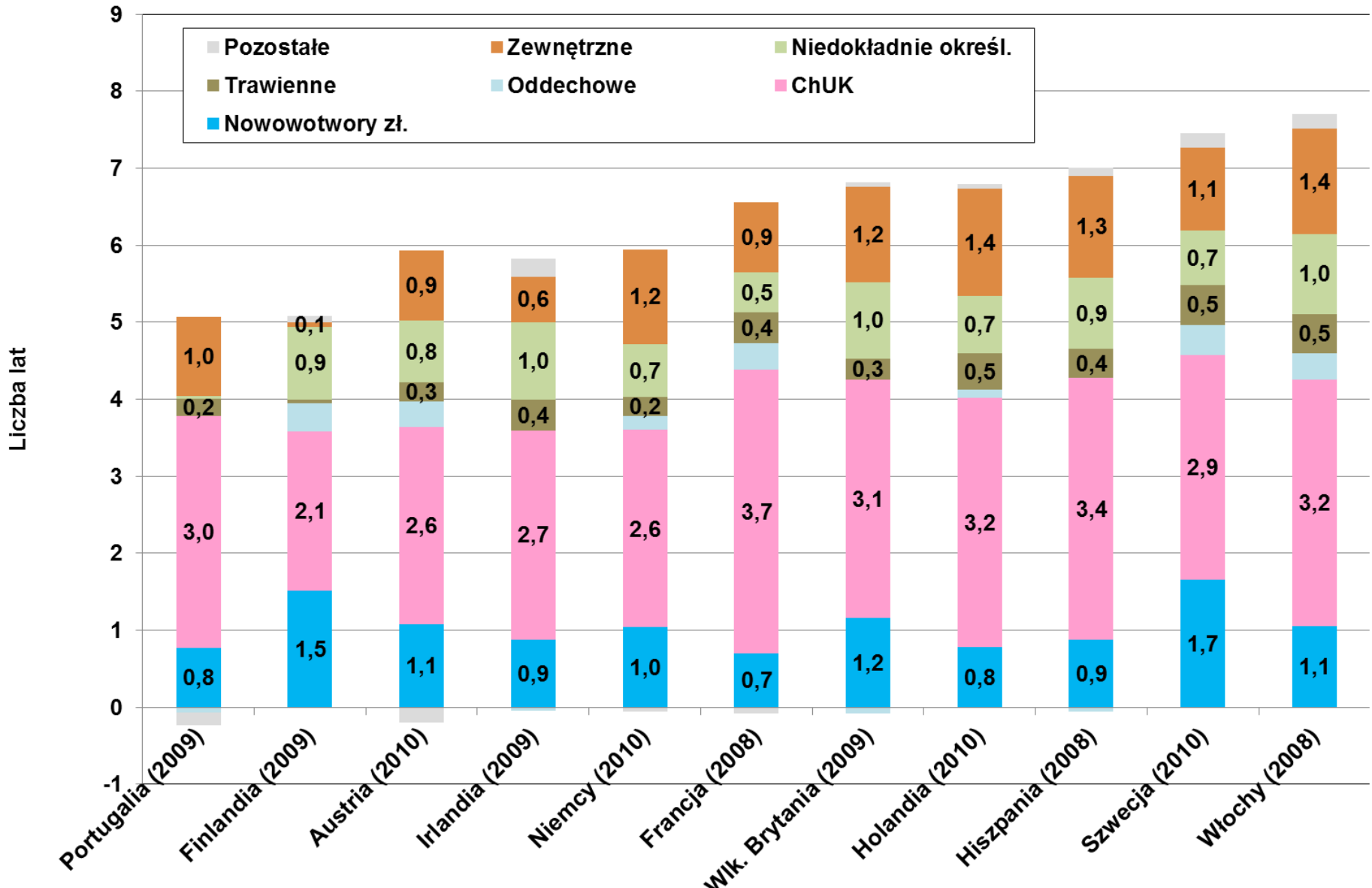
# **Długość życia Polaków – gdzie są rezerwy?**

Komitet Zdrowia Publicznego PAN

Warszawa, 2 lipca 2012

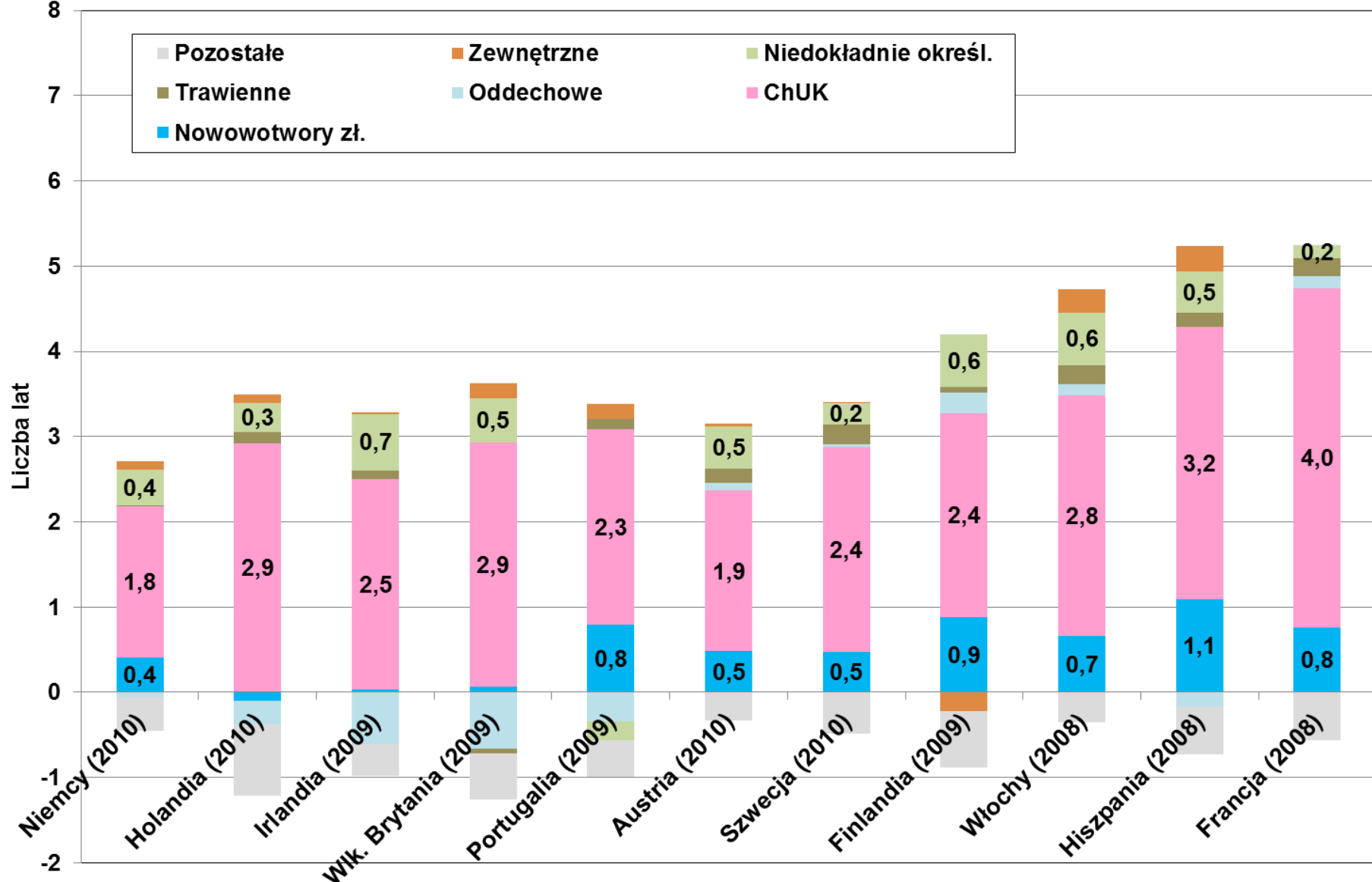
# Ile lat MĘŻCZYZNI w Polsce żyją krócej niż w innych krajach.

W jakich grupach chorób tkwią największe rezerwy? B Wojtyniak i wsp. PZH-NIZP



# Ile lat KOBIECY w Polsce żyją krócej niż w innych krajach.

W jakich grupach chorób tkwią największe rezerwy? B Wojtyniak i wsp. PZH-NIZP



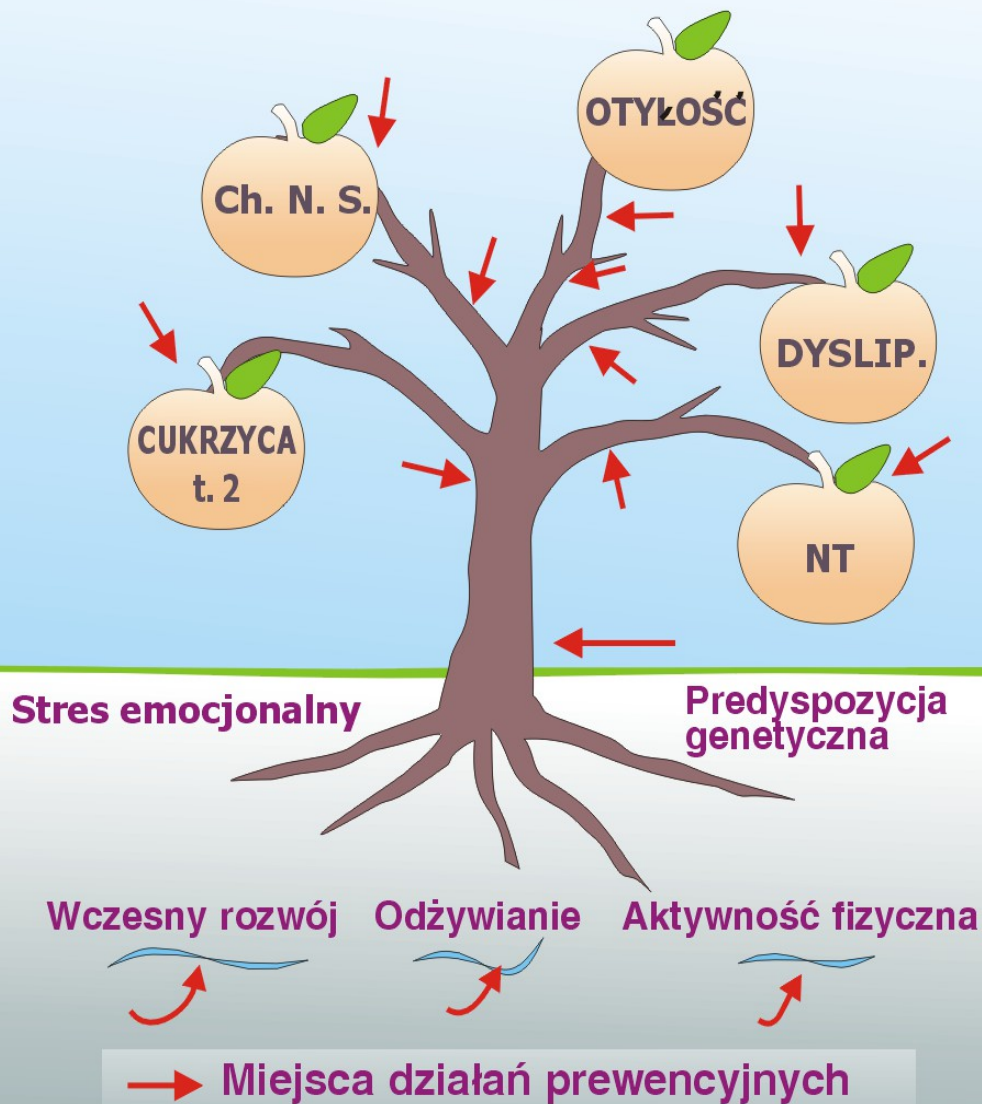
**Koszty chorób sercowo-naczyniowych w Polsce.  
Stan obecny i prognoza długoterminowa  
25.10.2012 r.**

**Opieka medyczna i leki związane z chorobami sercowo-naczyniowymi kosztują ..... mld zł rocznie**

**Produktywność utracona z powodu chorób sercowo-naczyniowych to koszt ..... mld zł rocznie**

- z powodu wcześniejszych emerytur i rent
- z powodu przedwczesnej umieralności
- z powodu przebywania na zwolnieniu lekarskim

# Drzewo prewencji



Trzeciorzędowa -  
- Trujące Owoce

Wtórna - Gałęzie

Wtórna - Pień

Pierwotna - Korzenie

Pierwotna - Gleba





**Professor Bernhard Meier**  
**Berno Szwajcaria**



**Professor Janina Stepinska Warszawa Polska**

# Prewencja chorób serca i naczyń

**Choroby niezakaźne – non-communicable diseases NCD**

**Choroby społeczne**

**Choroby cywilizacyjne**

**Tomasz Zdrojewski**



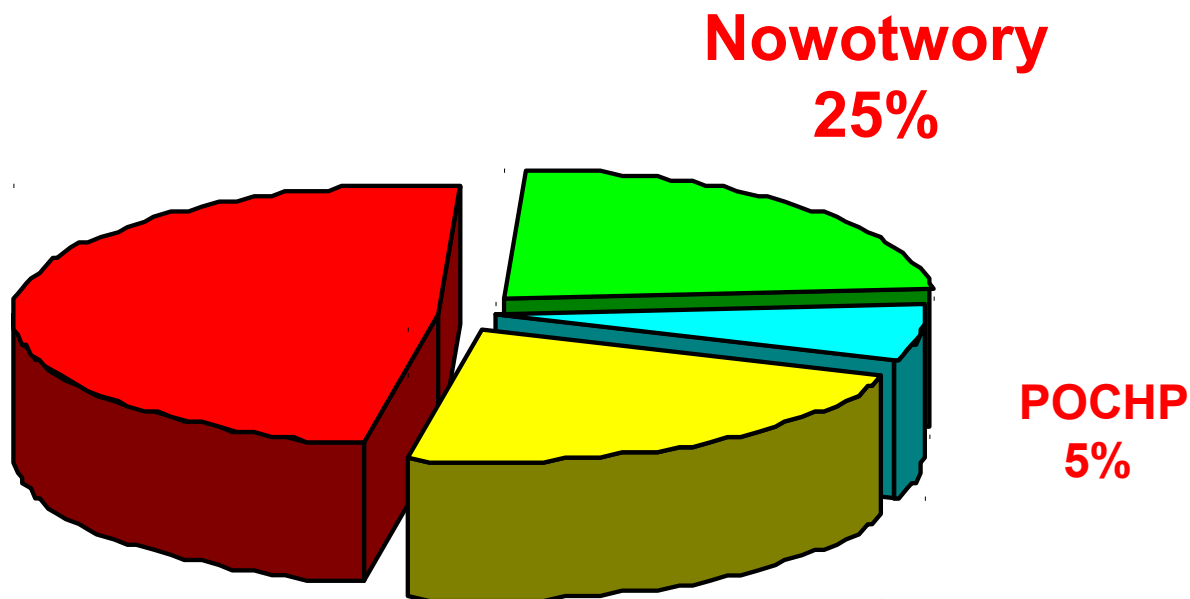
# Choroby serca i naczyń oraz cukrzyca powodują w Polsce:

- A. 25 - 30% zgonów
- B. 35 - 40%
- C. 45 - 50%
- D. 50 - 60%
- E. > 60%



# Przyczyny zgonów w Polsce

**Choroby  
serca i  
udary,  
cukrzyca  
50%**



**Inne w tym  
wypadki  
20%**



## **Choroby serca w Polsce powodują:**

- A. tyle samo zgonów u K i M**
- B. więcej zgonów u K**
- C. więcej zgonów u M**
- D. wszystkie odpowiedzi są nieprawdziwe**



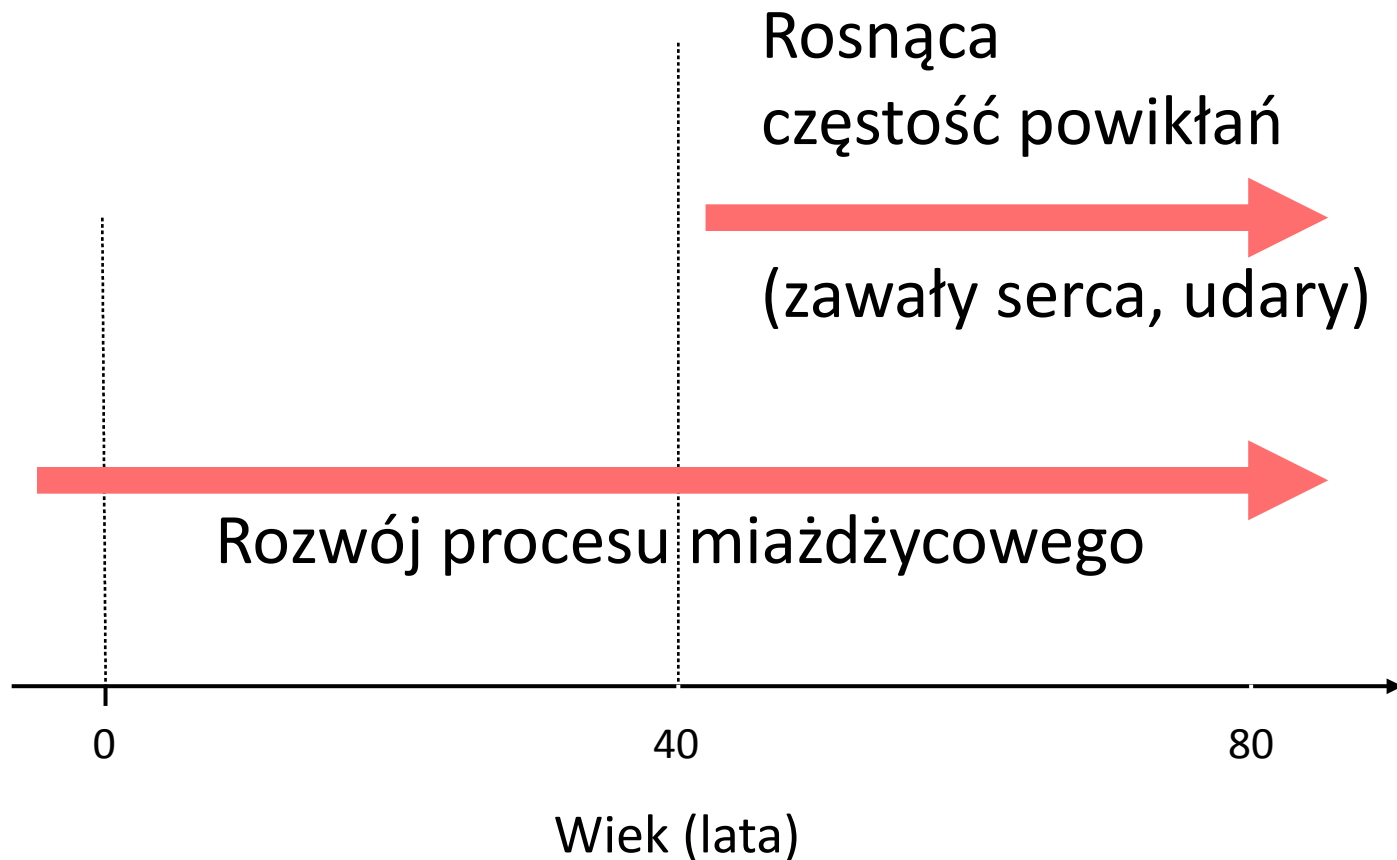
# Wykazano, że miażdżyca rozpoczyna się :

- A. w okresie płodowym
- B. ok. 10 roku życia
- C. ok. 20
- D. ok. 30
- E. ok. 40



# Jak zapobiegać zawałom i udarom?

## Historia naturalna miażdżycy





# Miażdżyca - aterotromboza

- przewlekły proces zapalny w ścianie aorty i dużych tętnic (wieńcowe, szyjne, nerkowe, biodrowe ...)
- rozpoczyna się w życiu płodowym
- choroba całego życia
- ogólnoustrojowa
- „programowana” w życiu płodowym
- wrażliwość na czynniki ryzyka



**Prawidłowo ciśnienie powinno być  
mniejsze niż:**

**A. 90 / 60 mmHg**

**B. 120 / 80**

**C. 130 / 85**

**D. 140 / 90**

**E. 160 / 100**



# Prawidłowo poziom cholesterolu powinien być mniejszy od:

- A. 250 mg / dl
- B. 230
- C. 210
- D. 190
- E. 170



# **The 2012 European Guidelines on Cardiovascular Disease Prevention in Clinical Practice**

*Chairperson*

**Joep Perk**

**Linneaus University**

**Institute for Health and Caring Sciences**

**Campus Kalmar, Sweden**

[www.escardio.org/guidelines](http://www.escardio.org/guidelines)

European Heart Journal 2012;33:1635–1701

European Journal of Preventive Cardiology 2012;19: 4:585-667



# On behalf of :

## The 5th Joint European Societies' Task Force on Cardiovascular Disease Prevention in Clinical Practice



European Society of  
Cardiology (ESC)



European Society of General Practice/  
Family Medicine (ESGP/FM/Wonca)



European Association for  
Cardiovascular Prevention &  
Rehabilitation (EACPR)



European Artherosclerosis Society  
(EAS)



European Society of  
Hypertension (ESH)



European Association for the Study  
of Diabetes (EASD)



International Society of  
Behavioural Medicine (ISBM)



International  
Diabetes  
Federation

International Diabetes Federation  
Europe (IDF-Europe)



European Heart Network (EHN)



European Stroke Organization (ESO)

[www.escardio.org/guidelines](http://www.escardio.org/guidelines)

European Heart Journal 2012;33;1635–1701

European Journal of Preventive Cardiology 2012;19: 4:585-667



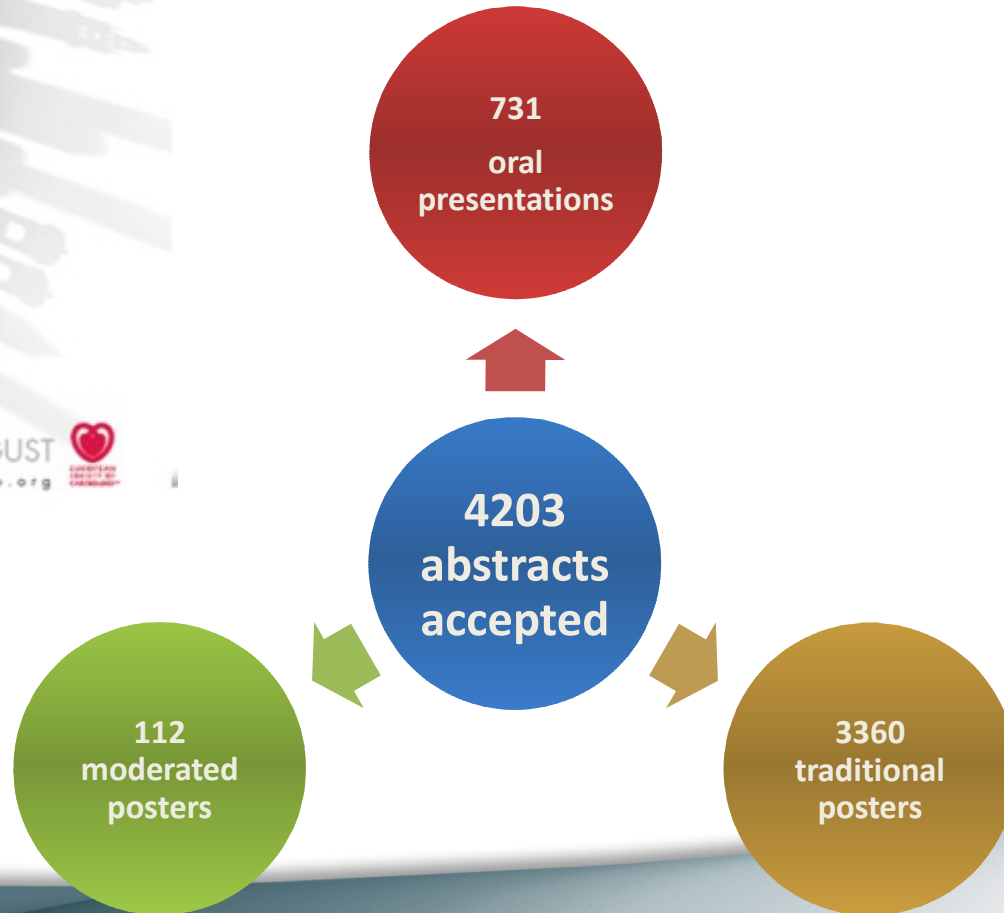




**EUROPEAN  
SOCIETY OF  
CARDIOLOGY®**

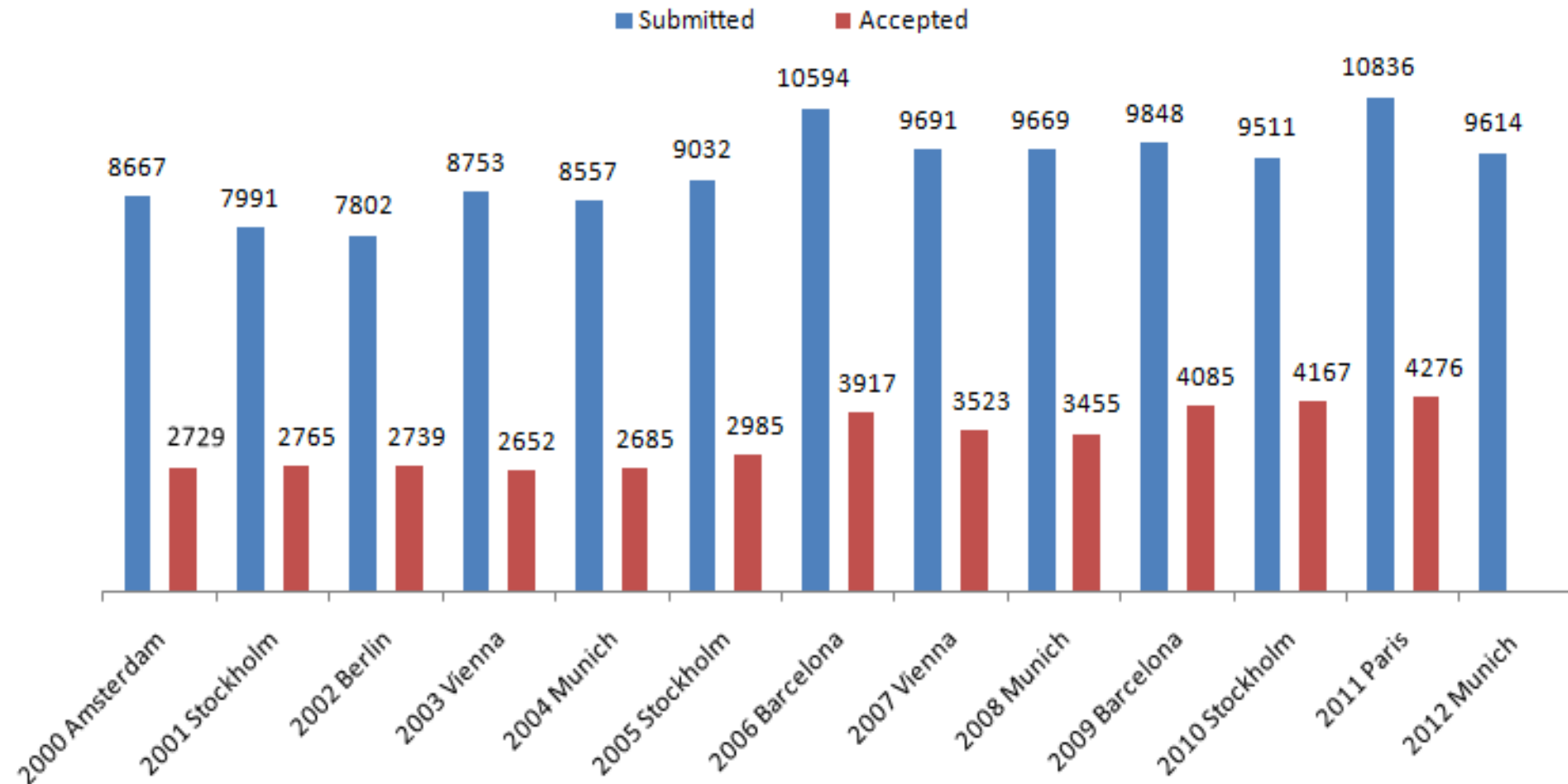
To reduce the  
burden of  
cardiovascular  
disease in Europe

9614 abstracts submitted  
4203 abstracts accepted



# Evolution abstract submission

ESC Congresses - Evolution submitted and accepted abstracts



# Major new key messages since the 2007 prevention guidelines

- Four levels of CVD risk.
- More European countries at low risk.
- The risk-age concept.
- The importance of psychosocial risk factors.
- Limited role of novel risk biomarkers.
- No exposure to passive smoking.
- The role of specific diet patterns.
- Underweight, a possible risk factor.
- Multimodal behavioural intervention effective.





# Major new key messages (continued)

- **Blood pressure:**

- Lifestyle measures needed for hypertensive patients,
- All major antihypertensives equal for clinical use,
- Target blood pressure <140/90 mmHg,
- Threshold values for ambulatory and home measurement.

- **Diabetes mellitus:**

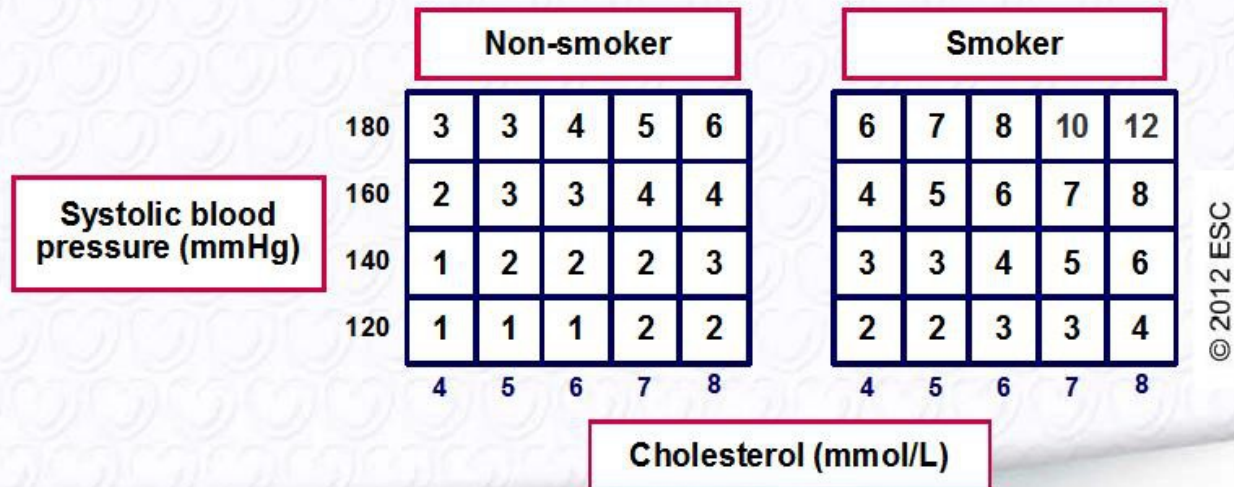
- Target HbA<sub>1c</sub> for CVD prevention: <7.0% (<53 mmol/mol),
- Target blood pressure <140/80 mmHg.

- **Blood lipids:**

- Target LDL-cholesterol:
  - <1.8 mmol/L for very high risk patients,
  - <2.5 mmol/L for high risk patients,
  - <3.0 mmol/L for for all others.

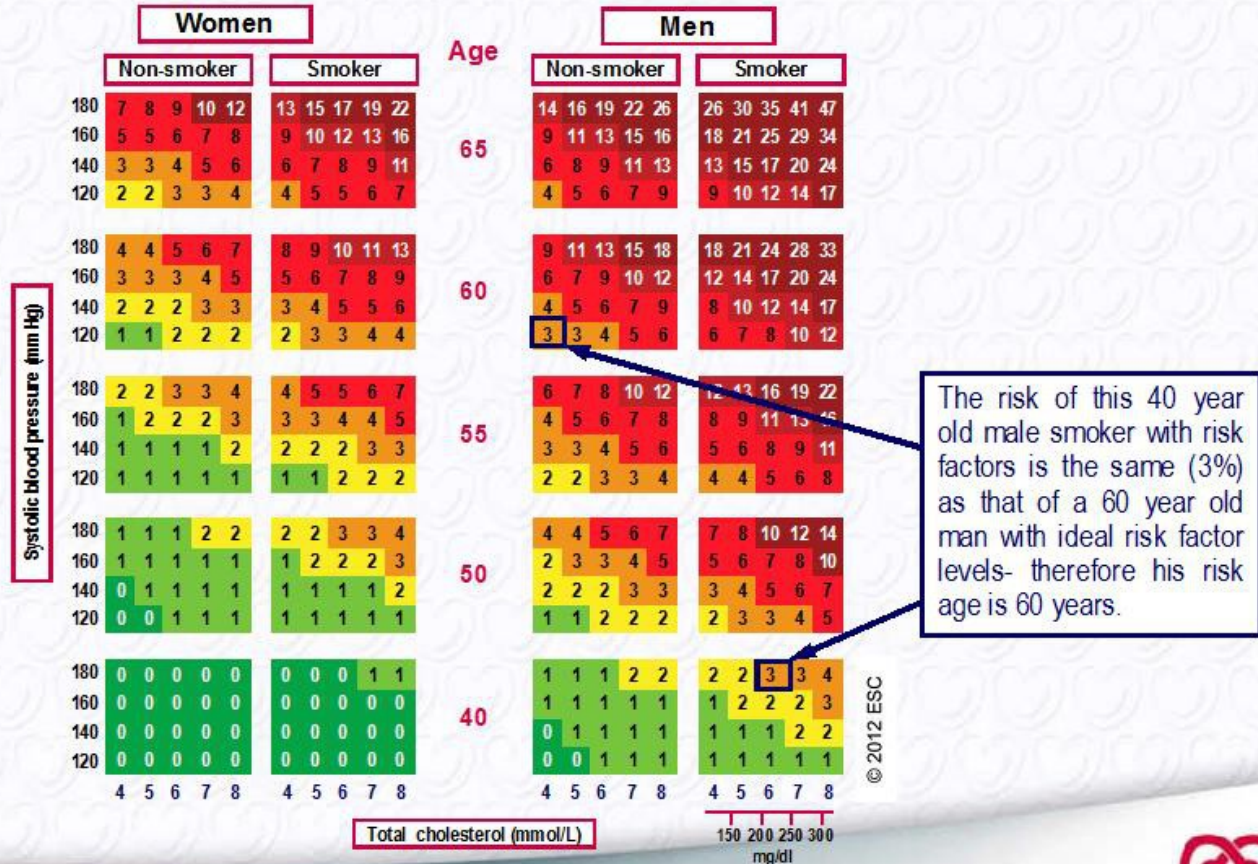
# Relative risk chart

- This chart may be used to show younger people at low absolute risk that, relative to others in their age group, their risk may be many times higher than necessary.
- This may help to motivate decisions about avoidance of smoking, healthy nutrition and exercise, as well as flagging those who may become candidates for medication.





# Risk age, a new concept



The risk of this 40 year old male smoker with risk factors is the same (3%) as that of a 60 year old man with ideal risk factor levels- therefore his risk age is 60 years.

See also: [www.heartscore.org](http://www.heartscore.org): HDL charts now included

[www.escardio.org/guidelines](http://www.escardio.org/guidelines)

European Heart Journal 2012;33:1635-1701

European Journal of Preventive Cardiology 2012;19: 4:585-667



# Classes of recommendations

Classes of recommendations	Definition	Suggested wording to use
<b>Classe I</b>	Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective.	Is recommended/ is indicated.
<b>Class II</b>	Conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of the given treatment or procedure.	
<i>Class IIa</i>	<i>Weight of evidence/opinion is in favour of usefulness/efficacy.</i>	<i>Should be considered.</i>
<i>Class IIb</i>	<i>Usefulness/efficacy is less well established by evidence/opinion.</i>	May be considered.
<b>Class III</b>	Evidence or general agreement that the given treatment or procedure is not useful/effective, and in some cases may be harmful.	Is not recommended.

# Chorobom serca można zapobiegać w:

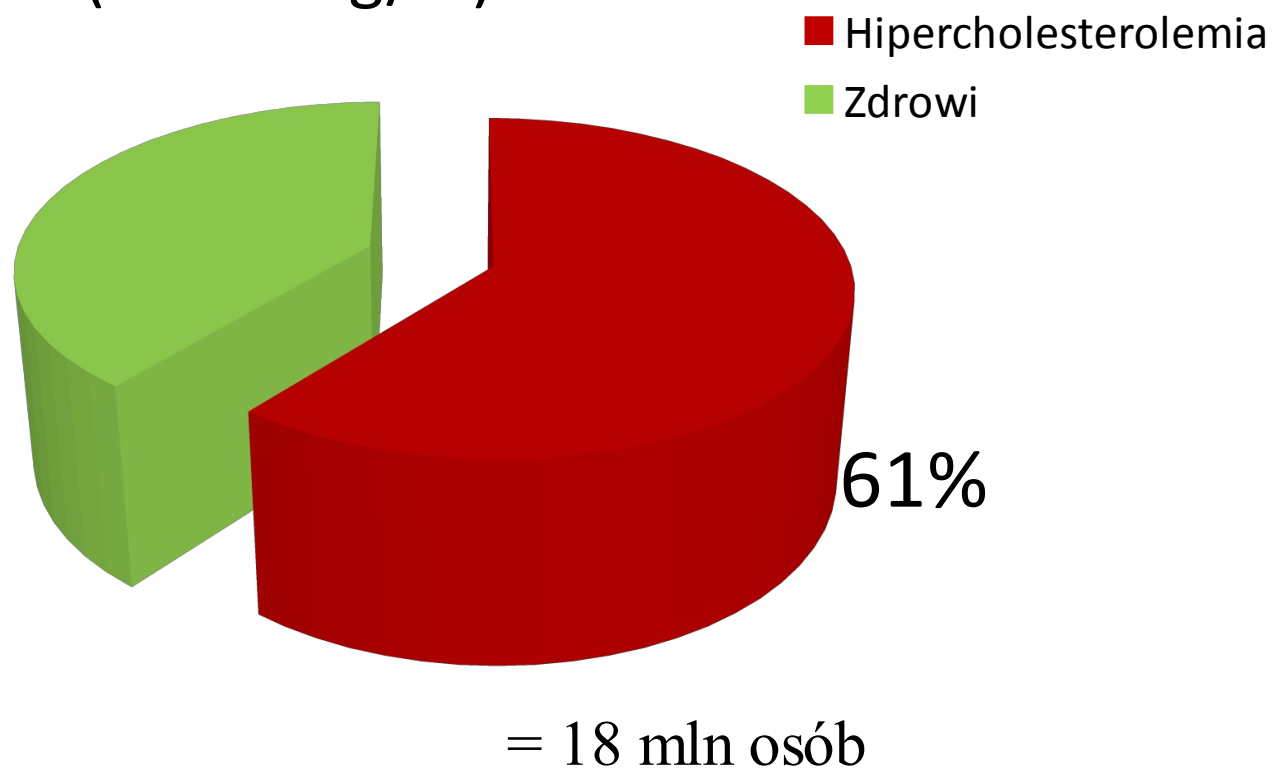
- A. 20%
- B. 30%
- C. 40%
- D. 60%
- E. 80%



# Chorobom naczyń i serca można zapobiec w 80%, a nowotworom w 40%

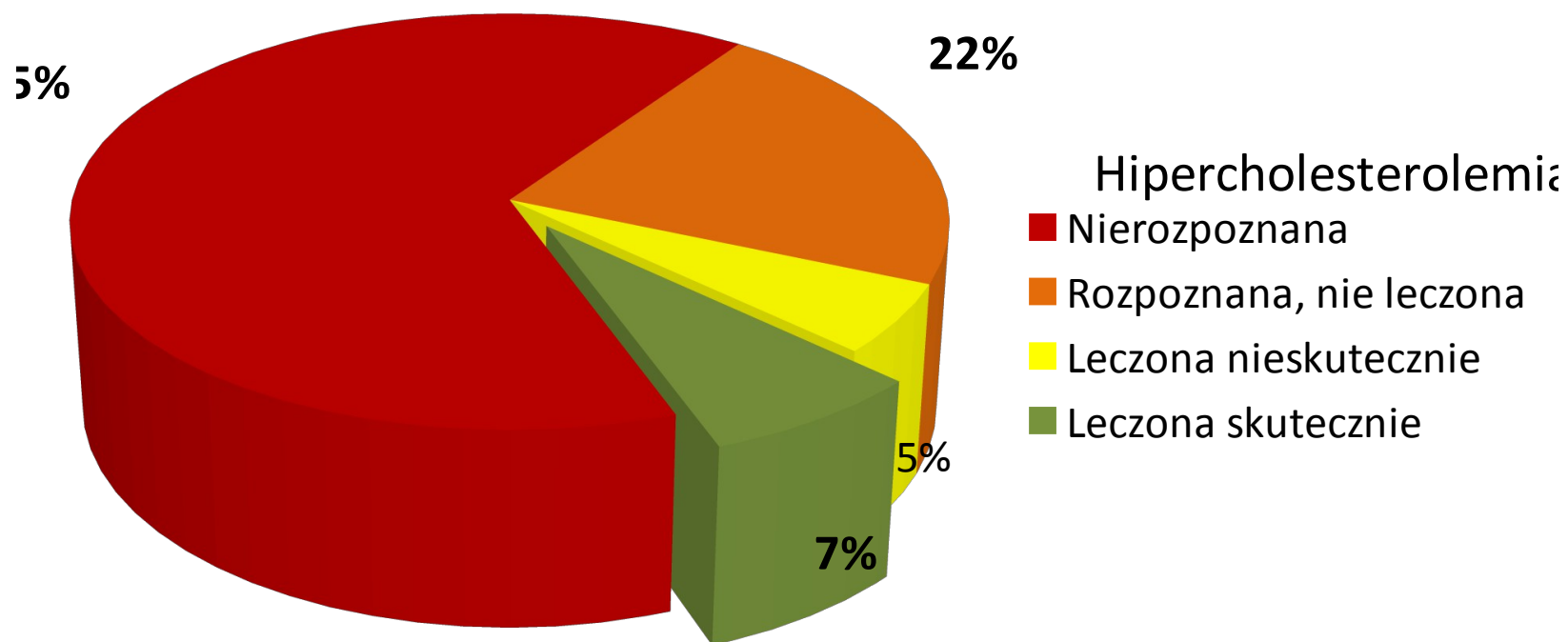
		Czynniki ryzyka			
		Papierosy	Niezdrowa dieta	Brak AF	Alkohol
Choroby niezakaźne	Choroby serca i udar mózgu	✓	✓	✓	✓
	Cukrzyca	✓	✓	✓	✓
	Nowotwory	✓	✓	✓	✓
	Choroby płuc	✓			

# Rozpowszechnienie hipercholesterolemii ( $\geq 190$ mg/dl)





# Kontrola hipercholesterolemii w Polsce





# Secondary prevention in the clinical management of patients with cardiovascular diseases. Core components, standards and outcome measures for referral and delivery

*A Policy Statement from the Cardiac Rehabilitation Section of the European Association for Cardiovascular Prevention & Rehabilitation. Endorsed by the Committee for Practice Guidelines of the European Society of Cardiology*

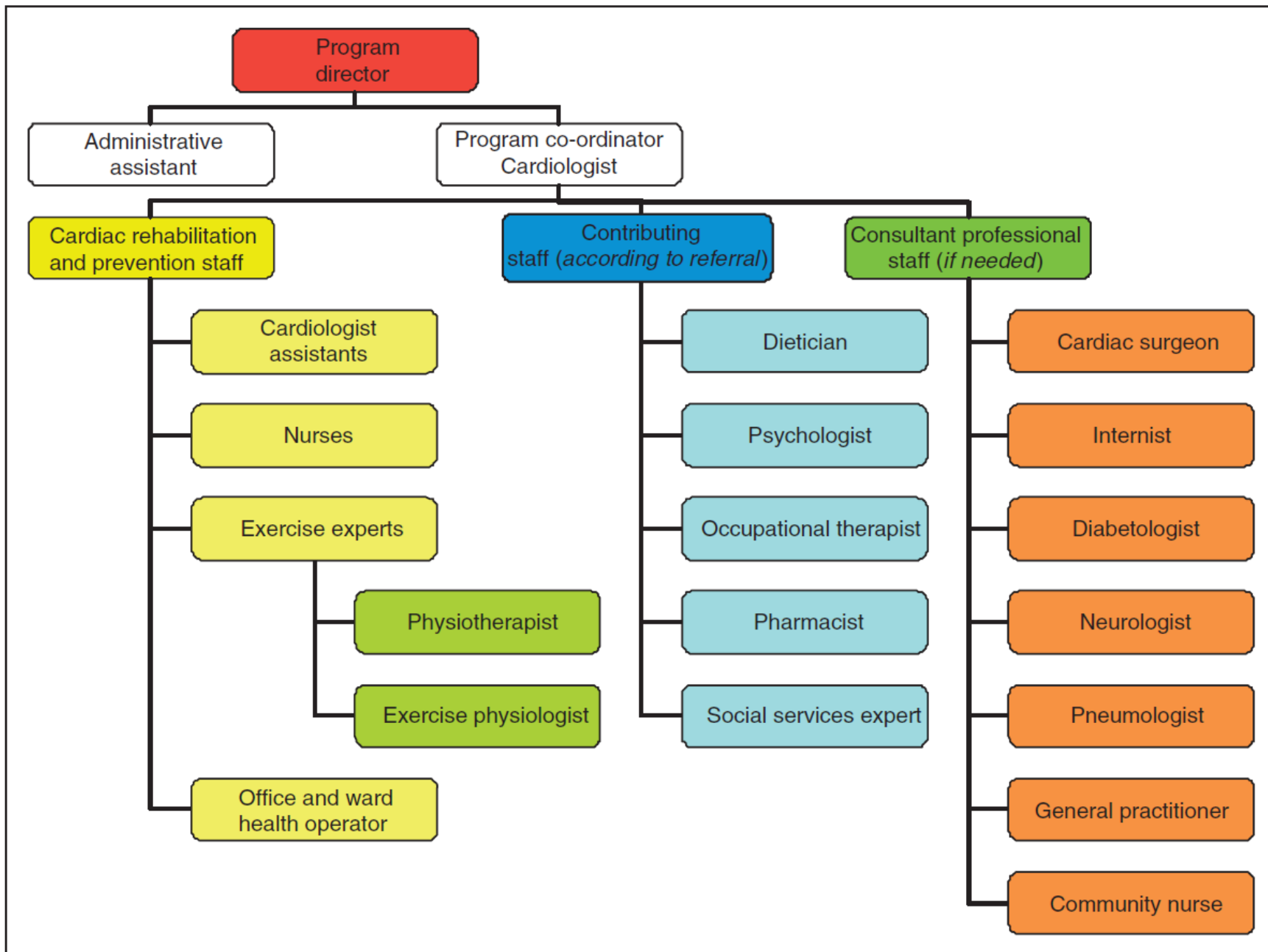
**Massimo F Piepoli<sup>1,2</sup>, Ugo Corrà<sup>3</sup>, Stamatis Adamopoulos<sup>4</sup>, Werner Benzer<sup>5</sup>, Birna Bjarnason-Wehrens<sup>6</sup>, Margaret Cupples<sup>7</sup>, Paul Dendale<sup>8</sup>, Patrick Doherty<sup>9</sup>, Dan Gaita<sup>10</sup>, Stefan Höfer<sup>11</sup>, Hannah McGee<sup>12</sup>, Miguel Mendes<sup>13</sup>, Josef Niebauer<sup>14</sup>, Nana Pogossova<sup>15</sup>, Esteban Garcia-Porrero<sup>16</sup>, Bernhard Rauch<sup>17</sup>, Jean Paul Schmid<sup>18</sup> and Pantaleo Giannuzzi<sup>3</sup>**

European Journal of Preventive  
Cardiology  
0(00) 1–18

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DOI: 10.1177/2047487312449597  
[ejpc.sagepub.com](http://ejpc.sagepub.com)





## Review

# **Secondary prevention through cardiac rehabilitation: from knowledge to implementation. A position paper from the Cardiac Rehabilitation Section of the European Association of Cardiovascular Prevention and Rehabilitation**

Massimo Francesco Piepoli, Ugo Corrà, Werner Benzer, Birna Bjarnason-Wehrens, Paul Dendale, Dan Gaita, Hannah McGee, Miguel Mendes, Josef Niebauer, Ann-Dorthe Olsen Zwisler and Jean-Paul Schmid

Heart Failure Unit, Cardiac Department, Guglielmo da Saliceto Hospital, Piacenza, Italy

Received 19 January 2009 Accepted 13 July 2009

Increasing awareness of the importance of cardiovascular prevention is not yet matched by the resources and actions within health care systems. Recent publication of the European Commission's European Heart Health Charter in 2008 prompts a review of the role of cardiac rehabilitation (CR) to cardiovascular health outcomes. Secondary prevention through exercise-based CR is the intervention with the best scientific evidence to contribute to decrease morbidity and mortality in coronary artery disease, in particular after myocardial infarction but also incorporating cardiac interventions and chronic stable heart failure. The present position paper aims to provide the practical recommendations on the core components and goals of CR intervention in different cardiovascular conditions, to assist in the design and development of the programmes, and to support healthcare providers, insurers, policy makers and consumers in the recognition of the comprehensive nature of CR. Those charged with responsibility for secondary prevention of cardiovascular disease, whether at European, national or individual centre level, need to consider where and how structured programmes of CR can be delivered to all patients eligible. Thus a novel, disease-oriented document has been generated, where all components of CR for cardiovascular conditions have been revised, presenting both well-established and controversial aspects. A general table applicable to all cardiovascular conditions and specific tables for each clinical disease have been created and commented. *Eur J Cardiovasc Prev Rehabil* 17:1–17 © 2010 The European Society of Cardiology



amsterdam

THE NETHERLANDS  
31 AUGUST -  
4 SEPTEMBER



ESC CONGRESS 2013

[www.escardio.org](http://www.escardio.org)



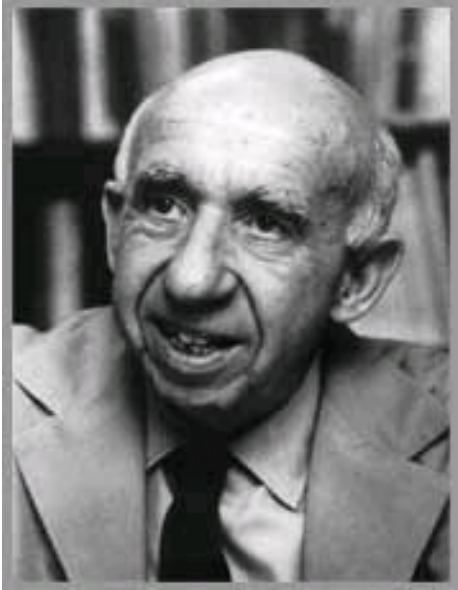
# Początek badań nad czynnikami ryzyka zawałów serca i udarów mózgu miał miejsce:

- A. około 1920
- B. 1930 - 1940
- C. 1940 - 1945
- D. 1950 - 1960
- E. 1970 - 1980



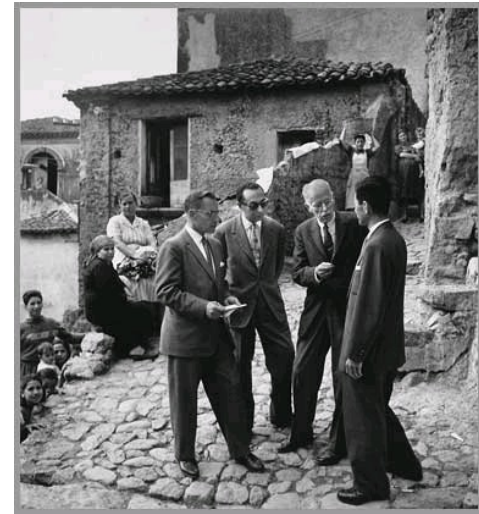


# Początki chorób niezakaźnych - NCD



Dr. Jeremiah  
Stamler

Pionier badań  
nad miażdżycą

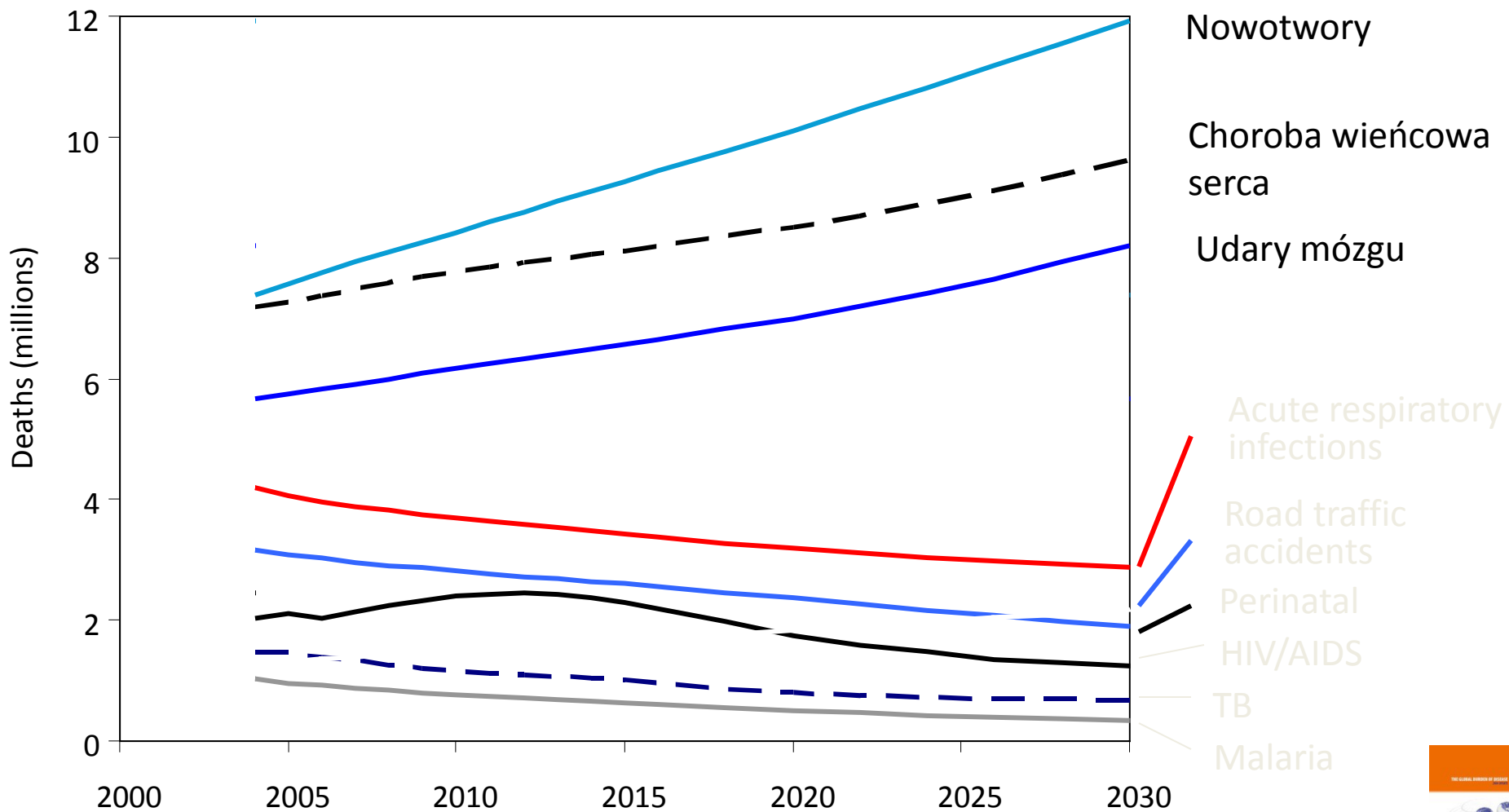


Nicotera, Italy, Seven Countries, 1957



Hydrochlorotiazyd

# Prognozy WHO na lata 2005-2030



# Abstract Graders

Target:

$\geq 7$  graders / abstract

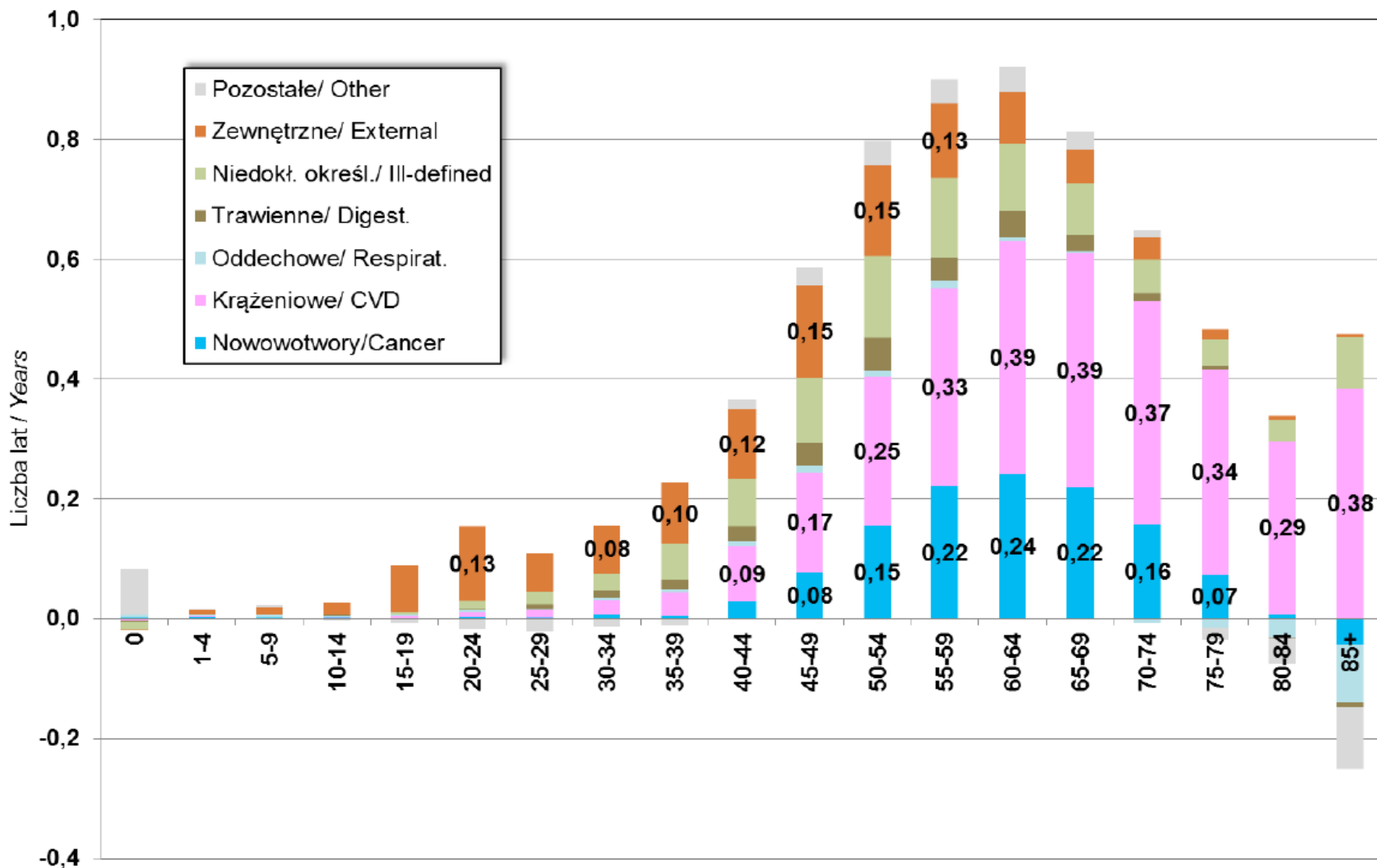
$\leq 100$  abstracts / grader

$\pm 800$  graders names

$\pm 9\ 500$  abstract submissions  
expected



**W jakim stopniu nadumieralność z powodu głównych przyczyn zgonów w grupach wieku MĘŻCZYZN w Polsce skraca długości ich życia w porównaniu z mieszkańcami Wielkiej Brytanii (obliczenia własne na podstawie danych WHO) / Contribution of differences in age-specific mortality from main groups of causes to shorter Polish males life expectancy in comparison to males in the UK (author's own calculation based on WHO mortality data)**



# Levels of evidence

<b>Level of Evidence A</b>	<b>Data derived from multiple randomized clinical trial or meta-analyses.</b>
<b>Level of Evidence B</b>	<b>Data derived from a single randomized clinical trial or large non-randomized studies.</b>
<b>Level of Evidence C</b>	<b>Consensus of opinion of the experts and/or small studies, retrospective studies, registries.</b>

# What is CVD prevention?

*“A coordinated set of actions, at public and individual level, aimed at eradicating, eliminating or minimizing the impact of cardiovascular diseases and their related disability.*

*The bases of prevention are rooted in cardiovascular epidemiology and evidence-based medicine”*

*A Dictionary of Epidemiology. 4th ed New York: Oxford University Press; 2001.*