Design and method: A total of 380 patients>65 years with hypertension, who underwent CABG procedure were studied and devided into four groups based on mean office BP achieved: a normotensive group (n=102), a HTN group with goal BP control (n=98), HTN group with poor BP control- (n=78) and HTN group with moderate BP control (n=102). Patients were followed for 48 months.

Results: The incidence of new onset AF during 48 months was significantly higher in HTN group with poor BP control (hazard ratio: 6.02; 96% confidence interval: 2.322-18.020; p<0,001). The incidence of new onset AF depended on long-term level of BP control.

Conclusions: In the long-term follow up patients after CABG procedure, poor BP control increased the risk of new onset AF in elderly patients with hypertension.

PP.LB03.09 THE USE OF ANTHROPOMETRIC INDICATORS IN PREDICTING HYPERTENSION IN EMPLOYEES OF PUBLIC UNIVERSITY RESTAURANTS, SÃO PAULO, BRAZIL

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Objective: Evaluate the best anthropometric predictor of the determination of arterial hypertension in adults among the indexes BMI, waist-to-height ratio (WHtR) and the Body Shape Index (ABSI).

Design and method: Cross-sectional study with a universe of a Public University of São Paulo City (N = 174) restaurant employees between 21 and 65 years old. The data collection involved structured socioeconomic questionnaire, blood pressure measurement, weight, height and waist circumference. Hypertension was defined as blood pressure > or = 140/90 mmHg or use of antihypertensive medication. Analyzed which of the studied indexes, presented itself as a better predictor of hypertension in this population through analysis of Poisson regression with robust variance were performed (confidence interval = 95%), with hypertension or not the outcomes. A comparison of the adjustment of the prediction models was through the Akaike Information Criterion (AIC).

Results: The prevalence of hypertension and overweight / obesity were respectively 23.0% and 60.9%. The best predictors were the ABSI ((RP=2.20; IC95% 1.19-4.07), BMI (RP=1.07; IC95% 1.011-1.13) and the WHtR index wasn't a good predictor (RP=3.07; IC95% 0.30-52.5), as can be analyzed by its values of prevalence ratio and confidence interval. There was a slight difference between the models with BMI (AIC = 201.19) and ABSI (AIC = 202.32). There were no significant differences in model fit for predicting BMI and ABSI. Thus, BMI was found to be the best anthropometric index to predict the chance of hypertension in this population.

Conclusions: These results corroborate the fact that the BMI index is being globally accepted as a predictor of hypertension.

PP.LB03.10 THE RELATIONSHIP OF A BODY SHAPE INDEX AND CARDIOMETABOLIC RISK FACTORS IN OBESE HYPERTENSIVE PATIENTS WITH DIFFERENT DEGREES OF HYPERTENSION

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Objective: It is known that accumulation of excess fat in the abdominal cavity leads to the development of diabetes mellitus, cardiovascular diseases and, as a consequence, increases the risk of premature death. "A Body Shape Index" (ABSI) is a recently proposed index that standardizes waist circumference for body mass index (BMI) and height.
The aim of our study was to investigate the relationship between the body shape index and cardiometabolic risk factors depending on the degree of arterial hypertension.

Design and method: 102 obese hypertensive patients on average age 54.9±9.94 matched in age and sex were examined. All patients underwent clinical examination, assessment of carbohydrate and lipids metabolism and determine the level of apolipoproteins (Apo B and A-I). According to the criteria of the IDF (2005) was diagnosed abdominal obesity (AO). The patients were divided into 3 groups according to the degree of hypertension.

Results: AO was diagnosed in 80% hypertensive patients with 1st degree, in 77.36% hypertensive patients with 2nd degree, and in 84.62% hypertensive patients with 3d degree. No significant relationship between ABSI and cardiometabolic risk factors was identified in hypertensive patients with 1st degree. While positive significant correlation between ABSI and systolic blood pressure (SBP) (R=0.27; p<0.05), pulse blood pressure (PBP) (R=0.31; p<0.05) and negative significant correlation with high density lipoprotein cholesterol (HDL-C) (R=-0.31; p<0.05) in hypertensive patients with 2nd degree has been revealed. Along with this ABSI was associated with very low-density lipoprotein cholesterol (VLDL-C) (R=0.37; p<0.05), triglycerides (TG) (R=0.34; p<0.05), with levels of Apo B (R=0.38; p<0.05) and Apo B/Apo A-I ratio (R=0.34; p<0.05) in hypertensive patients with 3d degree. No significant relationships with ABSI and indicators of carbohydrate metabolism in the surveyed groups.

Conclusions: Our data suggest that ABSI is associated with hemodynamic parameters and lipid profile in obese hypertensive patients with second degree, and lipid profile and indicators lipidotransport's system in obese hypertensive patients with third degree, but is not associated with carbohydrate metabolism.

PP.LB03.11 IS A COMPLETE RIGHT BUNDLE BRANCH BLOCK WORSE THAN AN INCOMPLETE ONE?

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Objective: To evaluate the risk in terms of cardiovascular morbi-mortality imposed by an incomplete right bundle branch block in comparison to a complete right bundle branch block.

Design and method: Design, scope and primary care framework or level, selection criteria, number of included subjects, number of responding subjects and number of dropouts, interventions (if applicable), response evaluation variables and methods. Statistical analysis, limitations, ethical-legal aspects.
Retrospective cohort study.
Population: 288 patients treated in an urban healthcare centre who did not have any cardiovascular disease at basepoint, and who underwent some sort of ECG between 2000 and 2013, as a result of which a right bundle branch block (RBBB) was found.
Variables: age; gender; presence of cardiovascular risk factors (CRF): arterial hypertension, hyperlipidemia, diabetes; presence of a complete or incomplete RBBB; cardiovascular accidents (CVA): heart failure, coronary heart disease, cerebrovascular disease, auricular fibrillation; mortality.

Results: 53.5% of patients (n=153) were male, the average age was 64.26 (SD:18).69.8% (n=201) had an incomplete RBBB, whereas 30.2% (n=87) showed a complete RBBB. The average of those with an incomplete RBBB was 60.71 (SD:17.8), that of those with a complete RBBB 70.78 (SD:16.4).
13.4% (n=27) of patients with an incomplete RBBB, and 20.7% (n=18) of those with a complete RBBB suffered from some CVA, but the differences between the groups were not statistically significant (p=0,119; OR: 1,68; IC 95%; 0,87 to 3,25). As regards the deaths, 3.5% (n=7) of patients with an incomplete RBBB died, and 11.5% (n=10) of those with a complete RBBB (p=0.008; OR: 3.60; IC 95%; 1.32 to 9.80). Adjusted for age and cardiovascular risk factors, the risk of death was 2.27 (IC 95%; 0,63; 8,14).

Conclusions: No differences were found in terms of the risk of suffering a cardiovascular accident or the risk of death between patients with a complete right bundle branch block and those with an incomplete RBBB.

PP.LB03.12 CARDIOVASCULAR MORBI-MORTALITY ASSOCIATED WITH RIGHT BUNDLE BRANCH BLOCK

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Objective: To assess the risks involved with right bundle branch block (RBBB) in cardiovascular morbi-mortality.