..ncvd..
national cardiovascular disease database
e-Newsletter
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GREETINGS!

NOTE FROM THE NCVD manager's desk

Three years have gone by since we started in 2005 with ups and downs along the way. After all the efforts we have put in, we can start to see the fruitful outputs.

I am proud to announce that the NCVD ACS annual report and publication of articles in MJM will be out soon for public reference. Furthermore, our own investigators have started to present NCVD data in local and international conferences.

This is one continuous journey; we are just at the beginning of it. Hope to see more publications in the future.

I would like to thank everyone who has worked hard in making this possible.

The success of NCVD is in YOUR hands!

Best wishes!

Message from the Chairman of Writing Committee

Congratulations to everyone for the success of NCVD ACS first annual report. The success is largely due to our collective responsibility for improvement of the registry. This is a race which has no finishing line as the report is not the end but it is just the beginning of this whole journey.

In future publications, as the registry matures, we hope to be able to refer to our own data set rather than extracting from external or foreign source. Meanwhile, the registry data is presented and discussed regularly in scientific meeting session of society meeting. At the same time, the availability of active website is assured as the medium to disseminate NCVD report. Moreover, we aimed for more publications in a reputable international journal in future.

Thus, we hope for continuity of support from everyone for more continuous publication.

Thank you.

Prof Dr Wan Azman Wan Ahmad

Chairman of Writing Committee

ANNOUNCEMENT!!!

- **Upcoming Events**

  CREATE 08 Post Conference Workshop:
  Registry User's Seminar

  Date : 22 – 23 October 2008 (1 ½ Day)
  Venue : Sunway Resort Hotel & Spa
  Objective : To learn the methods from extraction of registry data to the final interpretation of the data.

  For more details please access via http://www.crc.gov.my

- **Coming Soon!**

  

  - Annual Report of the NCVD-ACS Registry 2006
  - MJM (Medical Journal of Malaysia) supplement on patient registries whereby two contributions from NCVD;
    - Acute Coronary Syndrome (ACS) Registry: Leading the Charge for National Cardiovascular Disease (NCVD) Database
    - The foundation of NCVD-PCI registry: The Malaysia's First Multi-centre Interventional Cardiology Project

- Ms Hamimatunnisa Johar has joined us in NCVD Office in May 2008. Congrats and best wishes with her new job.

Summary of Annual Report of the NCVD ACS Registry 2006

The **Annual Report of the NCVD-ACS Registry 2006** report is the NCVD-ACS team's first publication. This report covers the following five main chapters;

1. Provision of Acute Coronary Care Services in Malaysia
2. Patient Characteristics
3. Clinical Presentations and Investigation
4. Treatment
5. Outcome

CCU centre survey was conducted to assess the availability of CCU services throughout Malaysia in year 2006. Results revealed a total of 73 coronary care units (CCU) in Malaysia with 12,534 of these CCU admissions attributed to Acute Coronary Syndrome (ACS). From this, it was estimated that the incidence of ACS admissions in 2006 was 47.1 for every 100,000 Malaysians. MOH Hospitals received 60% of these ACS admissions while Private Hospitals accounted for only 27% of the patients. This data shows that MOH sector is clearly under-resourced in terms of CCU beds, on-site Cardiologists, Catheterization Laboratories and Cardiac Surgical Facilities. Thus, the likelihood of ACS patients receiving intervention (PCI or CABG) is very much depended on the availability of these resources.

Meanwhile, 3,422 patients that were admitted with ACS were registered in NCVD ACS registry. These cases came from the 11 participating sites nationwide. Forty-nine percent of cases were Malay, 23% Chinese, 23% Indian and about 4% were from other ethnic backgrounds. Patients were mostly male (75%) and majority of them were relatively young. This report also revealed that 42% of the patients had ST segment elevation myocardial infarction (STEMI), 33% had non ST segment elevation myocardial infarction (NSTEMI) and 25% had unstable angina (UA). Further analysis indicated that STEMI patients had a younger mean age and comprised of more males, Malays and active smokers compared with NSTEMI and UA groups. Most of the patients in the STEMI group were in Killip class I and II.Five percent of STEMI patients were in Killip class IV while 3% of the NSTEMI group and none of the UA patients were in Killip class IV. These findings also showed that more than 90% of patients in each category had gone through either one of the following cardiac marker tests, which were Creatine Kinase-MB, Creatine Kinase, Troponin T or Troponin I as part of the clinical investigations conducted in the hospitals.

This report also summarizes the management pattern of these patients. Seventy percent of the STEMI patients received thrombolysis and only 8% proceeded directly to primary angioplasty. The highest proportion of patients who received thrombolytic therapy was among the younger age group, males and Malays. In addition, 20% of STEMI patients had PCI on the same admission with the male and Indian populations with the highest proportion of PCI done. As for NSTEMI/UA, the majority of patients were medically treated. Only 14% of NSTEMI and 9% of UA patients had PCI on the same admission. It should be noted that aspirin and statins were used in more than 90% of patients in all the ACS groups. It was also identified that there is an increasing trend of longer duration of hospitalization with increasing age.

The mortality rate for in-hospital ACS patient for the entire cohort of patients was 7% while 30-day mortality was 8%. The mortality rate was highest in the STEMI group followed by NSTEMI and lowest in UA. In STEMI patients, the use of fibrinolysis was associated with lower in-hospital and 30-day mortality rates. The important prognostic factors that have been identified for STEMI were higher Killip class, higher TIMI risk score and the presence of conventional risk factors. Higher Killip class was also an important prognostic factor for NSTEMI/UA.

The complete report may be accessed via
http://www.acrm.org.my/ncvd

THANK YOU to all of you for your continuous contribution to NCVD .....
Remember you are part of history making!