Abstract

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Stroke Risk Factors and Outcomes in Indigenous Versus Non-Indigenous Australians

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Background: Stroke risk factors are well known, but there is little data on the prevalence of stroke risk factors in Indigenous Australian cohorts. We aim to assess the risk factors and the outcomes after stroke and compare these in Indigenous and non-Indigenous Australians presenting with acute strokes to the Wagga Wagga Rural Referral Hospital.

Method: All suspected strokes presenting to hospitals within the Murrumbidgee local health district were transferred to the Wagga Wagga Rural Referral Hospital and prospectively assessed over a 5-year period from 01/10/2012 to 31/12/2017. Risk factors, stroke type, treatment and outcomes were analysed.

Results: 1843 patients were included. Of these, 45 patients (2.5%) were Indigenous. Indigenous patients were younger (mean age 59.9 versus 71.9 (p = <0.001)), more likely to be ever smokers (84.44% versus 53.35% (p = <0.001)), high cholesterol (73.33% versus 52.09% (p = 0.0048)), peripheral vascular disease (11.11% versus 4.68% (p = 0.047)) and diabetes (42.22% versus 22.88% (p = 0.0025)). Stroke types, treatment rates and outcomes on the modified Rankin Scale at 5 days was similar between the groups.

Conclusion: Indigenous Australians suffer stroke at a younger age than non-Indigenous Australians. They have a higher prevalence of smoking, dyslipidaemia, and diabetes. Outcomes at 5 days were similar between Indigenous and non-Indigenous Australians supporting the role of co-ordinated stroke unit care in improving the outcome after stroke in Indigenous patients.

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Predictors of Heart Failure Hospitalisations

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Background: Heart Failure (HF) results in significant health loss in New Zealand. Understanding the variables leading to admission and re-admission, locally and regionally, is required to better plan people-centred services, closer to home and to focus on populations and individuals with greatest need.

Method: A retrospective analysis of all HF admissions (across 5 District Health Boards (DHBs)) in the Midland region over a 5 year period to determine which demographic factors predicted admission and re-admission.

Results: Over the 5 year period, 1156 patients were responsible for 1733 HF admissions annually. Annualised rates of HF admissions increased over the 5 year period, but at slightly different rates by DHB. 27% patients were Maori/Pacific Islanders (M/PI).

Apart from age, ethnicity was the strongest predictor of admission, with M/PI rate overall twice that of Europeans. This difference was most apparent in the 40–74 age group where the M/PI rate was 5 times that of European.

Re-admission rates remained fairly consistent at 7% (15 days), 18% (90 days) and 25% (1 year), increasing only slightly (NS).

With re-admissions, deprivation and gender were the stronger predictors of re-admission, after age. Ethnicity does not independently predict re-admission.

Conclusion: Ethnicity is a powerful predictor of first HF admission especially in patients under 75 years. Deprivation status, not ethnicity is more predictive of readmission with HF. This raises potential focus areas for primary and secondary prevention of HF.

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Meeting Social and Cultural Needs During an Emergency

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Social and cultural barriers to care impact the journey to acute treatments for Aboriginal patients with chest pain and suspected acute coronary syndrome or neurological symptoms and suspected stroke. There is a recognised need to improve the quality of, and accessibility to, transfer and retrieval practices for these patients. Such actions improve the whole patient journey. The aim was to integrate supports to meet the cultural and social needs of Aboriginal patients into clinical pathways and procedures of emergency services.

A team of clinicians, clinical and Aboriginal health managers and Aboriginal community members with lived experience of heart disease and stroke identified key aspects.