mobility status on long-term outcomes in elderly patients with NSTEMI is unknown.

Methods: A retrospective analysis included 956 consecutive patients aged >85 years presenting with NSTEMI between 2010–2018. Mobility status was classified as independent, single point stick (SPS), 4-wheel frame (4WF) or wheelchair dependent. Guideline-directed medical therapy (GDMT) included aspirin, beta-blockers and statins. The primary outcome was all-cause mortality.

Results: Of 956 patients, 304 (33.7%) had independent mobility, 161 (17.9%) used a SPS and 402 (44.6%) used a 4WF. GDMT adherence did not vary significantly between the SPS and independent groups. However, adherence to GDMT was significantly lower in 4WF users ($p < 0.001$). Independent patients had higher rates of coronary angiography (19.5% vs 10% SPS vs 2% 4WF, $p < 0.001$) and had improved long-term survival (HR 0.68, 0.55–0.84, $p < 0.001$). SPS users did not experience reduced long-term survival ($p = 0.3$, whereas 4WF users had significantly greater long-term mortality (HR 1.5, 1.2–1.9, $p < 0.001$). This risk remained significant, albeit reduced (HR 1.3, 1.1–1.7, $p = 0.02$) after Cox-proportional hazard modelling.

Conclusion: There is an association between mobility status and prescription of GDMT and coronary angiography in elderly patients. Using a 4WF, but not a SPS, was associated with higher mortality.

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The abdominal aorta is one of the first vascular beds where atherosclerotic calcification is observed. Abdominal aortic calcification (AAC) can be identified at a fraction of the cost and radiation of coronary artery calcification tests. However, its prognostic significance remains unclear. We searched MEDLINE and Embase databases until March 2018 for studies reporting AAC and incident cardiovascular (CV) events, fatal CV events and all-cause mortality (ACM). Of 454 studies identified, 52 (46 cohorts, $n = 36,092$) were eligible. Summary risk ratios (RR) were estimated using random effects models comparing the lowest AAC group (referent) to all other AAC groups (any-more advanced AAC). Studies were mainly in chronic kidney disease (CKD) patients (57%) and the general population (26%), which were meta-analysed separately due to clinical heterogeneity. In studies of the general population, we identified moderate quality evidence that people with any-more advanced AAC had substantially higher risk of CV events; RR 1.83 (95% CI, 1.40 to 2.39); fatal CV events; RR 1.85 (95%CI, 1.44 to 2.39); and ACM; RR, 1.98 (95%CI, 1.56 to 2.53. In studies of CKD patients, we identified moderate-high quality evidence showing people with
any-one advanced AAC are at higher risk of CV events; RR, 3.47 (95% CI, 2.21 to 5.45), fatal CV events, RR, 3.69 (95% CI, 2.32 to 5.85) and ACM; RR, 2.30 (95% CI, 1.86 to 2.85). In conclusion, AAC identifies individuals at a clinically significant increased CV risk, particularly CKD patients or those with advanced AAC. Capturing and providing this information may help clinicians manage patients' cardiovascular risk.

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Readiness of Chinese Immigrants Diagnosed with CVD to use Web-based Health Information
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Background: Web-based interventions may potentially overcome linguistic and cultural barriers to secondary prevention for immigrants. However, the readiness to use the web for health is not known in this population.

Purposes: We examined readiness to use the web for health among Chinese immigrants with cardiovascular disease (CVD) and in comparison for the presence of another chronic condition.

Methods: Chinese immigrants were recruited from Chinese communities across New South Wales and surveyed for usage, confidence and perceptions of web-based health information, and health literacy. Participants with CVD (n = 90), chronic musculoskeletal conditions (n = 87) and without chronic condition (n = 154) were compared.

Results: Participants were aged mean 59 ± 16 years and 69% female. Participants with CVD were the oldest (71, 65, 49 years) and 48% perceived web-based health information as useful and important (46%). The most accessed information concerned lifestyle and medication (56% and 32%) which were similar to the other groups.

Confidence in web use was not associated with CVD diagnosis, but negatively associated with additional year in age (OR: 0.96; 95% CI: 0.93–0.99; p = 0.14), being female (OR: 0.53; 95% CI: 0.24–0.71; p = 0.02), and inadequate health literacy (OR: 0.57; 95% CI: 0.33–0.98; p = 0.042) after adjusting for age of migration and social support.

Conclusions: There is a strong potential to provide support and information for CVD secondary prevention via the web for Chinese immigrants with CVD if support is provided to improve confidence.

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Sex Disparities in the Management of Coronary Heart Disease in Primary Care in Australia
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Introduction: Primary care has been shown to be an important component for the secondary prevention of cardiovascular disease. Small-scale studies in Australia have reported coronary heart disease (CHD) management gaps in primary care from the late 1990s. Using the largest and most contemporary Australian general practice dataset (Mediclinemight), the aim of this study was to determine whether sex differences exist in the management of CHD patients.

Methods: General practice records of patients aged ≥18 years with a history of CHD and at least three visits in two years were analysed. Sex-specific, age-standardised proportions of patients (1) currently prescribed with medications; (2) assessed for cardiovascular risk factors; and (3) achieved treatment targets; that were recommended in the General Practice Management Plan for CHD and could be evaluated with Mediclinemight were reported.

Results: Altogether, records of 130,926 patients (46.7% women) from 438 sites across Australia were available from 2014–2018. Compared to men, women were less likely to be prescribed with recommended medications (prescribed ≥3 medications: women 44%, men 61%, p < 0.001) and to be assessed for risk factors. In contrast, women were more