

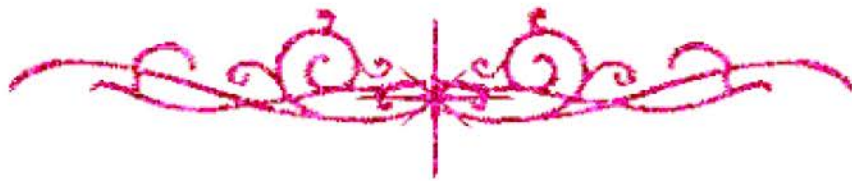
بسم الله الرحمن الرحيم



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شبكة المعلومات الجامعية التوثيق الالكتروني والميكرو فيلم



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جامعة عين شمس

التوثيق الإلكتروني والميكروفيلم


قسم

نقسم بالله العظيم أن المادة التي تم توثيقها وتسجيلها
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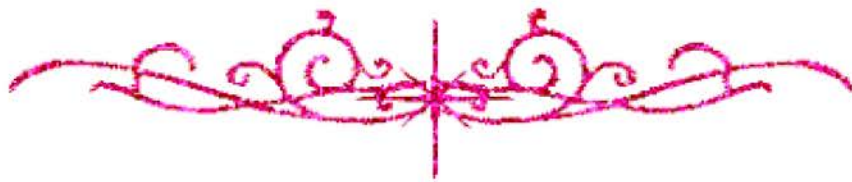


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بالرسالة صفحات

لم ترد بالأصل



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Risk Assessment of Coronary Heart Disease in Assiut University Staff

B10251

Thesis

Submitted for partial fulfillment of master
degree in cardiology

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2001

To My Son Moataz

And My Daughter

Miral

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* ARABIC SUMMARY

Abbreviations

AUS: Assiut University Staff
BMI: Body Mass Index
BP: Blood Pressure
CHD: Coronary Heart Disease
CVD: Cardiovascular Disease
DBP: Diastolic Blood Pressure
ECG: Electrocardiogram
EMR: Eastern Mediterranean Region
HDL: High Density Lipoprotein
Ht.: Height
IDL: Intermediate Density Lipoprotein
LDL: Low Density Lipoprotein
LP (a): Lipoprotein (a)
LVH: Left Ventricular Hypertrophy
MI : Myocardial Infarction
NCEP: National Cholesterol Education Program
RW: Relative Weight
SBP: Systolic Blood Pressure
TC: Total Cholesterol
TG: Triglyceride
VLDL: Very Low Density Lipoprotein
WHO: World Health Organization
Wt.: Weight

INTRODUCTION

AND

AIM OF THE

STUDY

INTRODUCTION

Coronary heart disease (CHD) continues to be a leading cause of mortality and morbidity among adults in Europe and North America (Mc Govern, et al., 1992).

Also in Egypt

Although there is a downward trend in cardiovascular mortality rates, morbidity and mortality rates from CHD remain high and are of great concern to clinicians and health officials.

About 700,000 patients are hospitalized each year with a diagnosis of acute myocardial infarction (MI) in the United States of America, and about 400,000 people die from CHD each year in the USA, accounting for about one-third of all deaths. CHD costs the USA about 15 percent of the annual USA health care budget. Each year, there is more hospitalization for CHD than for any broad diagnostic group with the exception of births, all respiratory diseases, all digestive diseases, and all injuries (Lane, 1995).

The overall objective of CHD prevention both in patients with clinically established CHD or other atherosclerotic disease and in high risk individuals is the same: to reduce the risk of subsequent major CHD events or other vascular events and thereby reduce mortality and prolong survival.

T F R
(task force report, 1998).

Modest reductions in multiple risk factors are likely to reduce CHD risk more than aggressive reduction of a single risk factor while ignoring others; this can be appreciated from the Coronary Risk Chart.

Thus even modest success in term of risk factor reduction may be associated with a useful and substantial reduction in risk and should stimulate a positive and encouraging attitude from physicians.

From these considerations, it will be apparent that the objective should be to reduce absolute coronary heart disease risk as far as possible based on multiple risk factor intervention.

In any given age group, lifestyle changes should be encouraged which will reduce absolute coronary heart disease risk towards the lowest level possible for a person in that age group (Task Force Recommendations,1998).

Aim of this study:

1. To assesses the risk of developing CHD for AUS.
2. To suggest the prevention programs and lifestyle modification for prevention of CHD among AUS.
3. To modify and update the clinical and laboratory data included in the questionnaire used in "Health Check up Unit for AUS".