Acute Myocardial Infarction Hospitalization Statistics: Apparent Decline Accompanying an Increase in Smoke-Free Areas

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INTRODUCTION

Smoking is a major cause of coronary heart disease. Although the exact mechanism is not completely understood, the consumption of even small quantities of cigarettes is associated with acute myocardial infarction (AMI). Recently, exposure to environmental tobacco smoke (ETS) has also been shown to cause AMI.1 In the US and Europe, recent evaluations of comprehensive regulations to
reduce exposure to ETS have shown a decline in AMI. This suggests that previous assessments of the contribution of ETS to all AMI incidence may have been seriously underestimated. 2-5 The purpose of the present study is to determine the short-term impact of antismoking legislation that came into force in Spain in 2006 by analyzing the evolution of AMI incidence in a specific population group using hospital discharge data.

**METHODS**

The study is based on the Barcelona metropolitan area (5 million inhabitants), a separate healthcare region within Catalonia (Spain). Since 1991, regional acute care hospitals have reported activity through the Catalan minimum, basic data set on hospital discharge (CMBDAH). The database includes patient characteristics—like place of residence, age and gender—and hospitalization data—like International Classification of Diseases Ninth Revision (ICD-9) main and secondary diagnoses. Data are compiled and analyzed, and statistics and reports are published periodically; information is made available on demand for specific studies. In 2003, the CMBDAH underwent a major change with the introduction of a new data management application.

For the present study, we collected data on all hospital discharges financed by the Catalan Health Service (CatSalut) for 2004-2006. All patients aged >24 residing in the area and with a main diagnosis of AMI (ICD-9-CM code 410.x1) were included. CatSalut individual identification numbers were used to check data and eliminate duplicate records caused by interhospital patient transfers. The CatSalut population registry at June 30 of each year provided the denominators by establishing the estimated at-risk population as that recorded at the midpoint of each year). Age- and gender-specific annual hospitalization rates were calculated for each year with 95% confidence intervals (CI) to facilitate comparisons. Standardized rates were computed by the direct method using Epidat 3.1 software and taking the 2006 population as standard. 7

On January 1, 2006, major antismoking legislation (Spanish law 28/2005) came into effect. This included a ban on advertising, a reduction in sales outlets, and a workplace smoking ban (with exemptions for cafés, bars, restaurants, night clubs, and discotheques). Earlier legislation had been limited in scope and implementation had varied greatly. 8 The new law received extensive public attention and media coverage, and its implementation in workplaces (including retail stores and other enclosed public places) was considered satisfactory.

**RESULTS**

Table 1 shows AMI hospitalization rates for 2004-2006. In 2004, rates were higher than in 2005 for most age groups, but CIs overlapped. In 2006, rates were lower than in 2005 for all age groups, and total adjusted rates CI for men did not overlap.
Table 2 summarizes absolute and relative changes in adjusted rates by gender. In men, the decline in 2006 (-10.68%) was much greater than in 2005 (-5.69%); in women, it was only slightly greater (8.76% vs 6.85%). This decline is apparent in all age groups except men aged <45. If the percentage decline in 2006 had been the same as that of 2005, recorded AMI hospitalizations for 2006 would have risen by 156.

DISCUSSION

The present study shows a populationwide reduction in AMI hospitalization rates in the Barcelona healthcare area. Although we found AMI rates in older age groups fell between 2004 and 2005, the decline seems to have increased after antismoking legislation banning smoking from workplaces and many enclosed public spaces came into force in 2006.

The new law introduced strict regulations affecting workplaces but granted exemptions to bars and restaurants. Recent studies document subsequent large-scale improvements in population exposure to ETS, both in perceived and in actual environmental data, and incidence of smoking in the Barcelona population has fallen. Clearly, though, other relevant changes in the management of ischemic coronary disease and its risk factors have occurred in recent years. These include offering incentives to primary health care providers to increase treatment for hypertension, hyperlipidemia and diabetes, and to help smokers break the habit; the establishment of standard protocols for emergency AMI care (including prehospital fibrinolysis); and the use of primary or secondary angioplasty to treat AMI episodes. These developments have happened gradually and although they may have contributed to the decline recorded in 2005, they cannot explain the greater decline in men in 2006.

The present study is limited as it is based on secondary data from the CMBDAH database, a standard resource, and has been restricted to publicly-funded hospital care. However, population-based epidemiologic studies estimate similar figures for AMI hospitalization. Another limitation is the short time-frame (3 years), although this is due to changes introduced to CMBDAH in 2003 to upgrade database quality. One further limitation is the fact that the population estimate could have been slightly exaggerated, although this would affect all 3 year-groups equally. Major changes in the foreign immigrant population registries occurred in 2001-2003, but not in 2004-2006. In this densely populated area, access to specialized AMI care is relatively swift and homogeneous. However, these results should be confirmed by further studies.

REFERENCES


