These results demonstrated that most, but not all questionnaires addition to other established traditional risk factors. Results: Incidence of cancer and ASCVD according to TC/LDL-C/non-HDL-C were shown in figure. Compared with the lowest quartile, the upper-most quartile of TC, LDL-C and non-HDL-C were all significantly associated with increasing risk of ASCVD (HR 1.55, 95% CI 1.37–1.70, P trend <0.001; HR 1.6, 95% CI 1.05–2.8, P trend=0.005). On the contrary, compared with the lowest quartile, the upper-most quartile of TC, LDL-C and non-HDL-C were all significantly associated with decreasing risk of cancer (HR 0.84, 95% CI 0.74–0.95, trend –0.004; HR 0.82, 95% CI 0.72–0.93, P trend =0.021; HR 0.89, 95% CI 0.70–0.90, P trend <0.001) and these associations were still exist after excluding incident cancers in the first 4 years follow-up (HR 0.79, 95% CI 0.65–0.96; HR 0.81, 95% CI 0.66–0.98; HR 0.77, 95% CI 0.64–0.94). In analyses, compared with the lowest quartile, the upper-most quartile of TC and non-HDL-C were mainly negatively associated with liver cancer (HR, 0.26, 95% CI 0.16–0.41; HR 0.27, 95% CI 0.18–0.43) and stomach cancer (HR, 0.63, 95% CI 0.41–0.98; HR, 0.53, 95% CI 0.34–0.83). After excluding incident cancers in the four years follow-up, compared with the lowest quartile, the upper-most quartile of TC was still mainly negatively associated with liver cancer (HR, 0.39, 95% CI 0.20–0.76); and the upper-most quartile of non-HDL-C was still negatively associated with liver cancer (HR, 0.37, 95% CI 0.19–0.70) and stomach cancer (HR, 0.41, 95% CI 0.19–0.83).

Results: Among 12 countries sampled have evidence-based national guide lines in place around managing non-communicable disease in primary care. More significant gaps exist in areas such as initiatives to raise awareness around stroke; only 3 of the countries observed World Stroke Day in 2016 and 7 countries reported that less than 20% of patients: median 18% (range: 6% to 58%) over the age of 40 who were not already being monitored for hypertension, were screened by blood pressure testing. Even fewer were screened for atrial fibrillation; in 11 out of 12 countries less than 20% of patients: median 14% (range: 2% to 43%) over the age of 65 were screened using pulse palpation or electrocardiogram.

Conclusions: These results demonstrated that most, but not all questionnaires relating lifestyle habits were associated with the presence of ASCVD and cancer.

Conclusions: In this Kailuan cohort study about men, we found that high level of TC, LDL-C and non-HDL-C were associated with increasing ASCVD incidence. However, these lipid profiles are negatively associated with cancer incidence and these associations with cancer risk can’t entirely explained by the predichlial factors. It warns that we should pay more attention to the potential health risks of cholesterol-lowering.

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Methods: We prospectively examined the association between TC, LDL-C, non-HDL-C and ASCVD or cancer among 68769 Chinese male adults enrolled in the Kailuan study who were free of cardiovascular disease and cancer at baseline (2006 to 2007). Follow up about 8 years until cardiovascular disease diagnosis or cancer diagnosis or death or until December 31 in 2014. 2916 men developed ASCVD and 1884 men developed cancer. Cox regression models were used to estimate hazard ratio (HR) and their 95% confidence intervals (CI), multivariable analysis adjusted for age, cigarette smoking, alcohol consumption, physical activity, hypertension, diabetes mellitus and BMI at baseline.

Results: Incidence of cancer and ASCVD according to TC/LDL-C/non-HDL-C were shown in figure. Compared with the lowest quartile, the upper-most quartile of TC, LDL-C and non-HDL-C were all significantly associated with increasing risk of ASCVD (HR 1.55, 95% CI 1.37–1.70, P trend <0.001; HR 1.6, 95% CI 1.05–2.8, P trend=0.005). On the contrary, compared with the lowest quartile, the upper-most quartile of TC, LDL-C and non-HDL-C were all significantly associated with decreasing risk of cancer (HR 0.84, 95% CI 0.74–0.95, trend –0.004; HR 0.82, 95% CI 0.72–0.93, P trend =0.021; HR 0.89, 95% CI 0.70–0.90, P trend <0.001) and these associations were still exist after excluding incident cancers in the first 4 years follow-up (HR 0.79, 95% CI 0.65–0.96; HR 0.81, 95% CI 0.66–0.98; HR 0.77, 95% CI 0.64–0.94). In analyses, compared with the lowest quartile, the upper-most quartile of TC and non-HDL-C were mainly negatively associated with liver cancer (HR, 0.26, 95% CI 0.16–0.41; HR 0.27, 95% CI 0.18–0.43) and stomach cancer (HR, 0.63, 95% CI 0.41–0.98; HR, 0.53, 95% CI 0.34–0.83). After excluding incident cancers in the four years follow-up, compared with the lowest quartile, the upper-most quartile of TC was still mainly negatively associated with liver cancer (HR, 0.39, 95% CI 0.20–0.76); and the upper-most quartile of non-HDL-C was still negatively associated with liver cancer (HR, 0.37, 95% CI 0.19–0.70) and stomach cancer (HR, 0.41, 95% CI 0.19–0.83).

Methods: The study used primary and secondary research to assess how 12 countries: Belgium, France, Germany, Italy, Netherlands, Norway, Russia, Spain, Sweden, Turkey, UK and US, defined stroke risk rate and stroke risk factors. We developed a conceptual framework to evaluate different aspects of stroke prevention practices. The indicators captured the existence of awareness campaigns, the use of evidence-based national guidelines, the development of stroke registries and screening practices for hypertension and atrial fibrillation. The primary study surveyed 600 physicians – 50 physicians in each country - to identify the proportion of patients screened for blood pressure and atrial fibrillation. The indicators were constructed to take a composite approach to identifying country performance and where any improvements could be made.

Results: 7 out of the 12 countries reported that less than 20% of patients: median 18% (range: 6% to 58%) over the age of 40 who were not already being monitored for hypertension, were screened by blood pressure testing. Even fewer were screened for atrial fibrillation; in 11 out of 12 countries less than 20% of patients: median 14% (range: 2% to 43%) over the age of 65 were screened using pulse palpation or electrocardiogram.

Conclusions: The findings show that there is contrast in how stroke prevention is addressed across countries and there is room for improvement even in the more advanced economies. Although national evidence-based guidelines are gener-ally in place, screening for hypertension and atrial fibrillation is not systematically performed in clinical practice. Additionally, more efforts are needed to develop national stroke registries and improve education and population awareness around stroke risk factors.

Methods and results: We utilized the data from Taiwan National Health Insurance Research Database (NHIRD) to perform a population-based cohort study (1997–2008). A total of 2062 patients with ADPKD were selected from one million general population after excluding those patients with follow-up duration of less than 1 year, missing data, age less than 18 years old, receiving renal replacement therapy, and concomitant diagnoses of AMI. We up those patients without ADPKD group by matching study cohort with age, gender, income and urbanization with 1:10 ratio (n=20620). After adjusting for age, gender and comorbidities (3.9% vs. 0.97%, p<0.0001). In addition, Kaplan-Meier analysis demonstrated that cumulative incidence of AMI was remarkably higher in ADPKD than in the non-ADPKD group (all p<0.001). In addition, Kaplan-Meier analysis demonstrated that cumulative incidence of AMI was remarkably higher in ADPKD than in the non-ADPKD group (all p<0.001). In addition, Kaplan-Meier analysis demonstrated that cumulative incidence of AMI was remarkably higher in ADPKD than in the non-ADPKD group (all p<0.001). In addition, Kaplan-Meier analysis demonstrated that cumulative incidence of AMI was remarkably higher in ADPKD than in the non-ADPKD group (all p<0.001). In addition, Kaplan-Meier analysis demonstrated that cumulative incidence of AMI was remarkably higher in ADPKD than in the non-ADPKD group (all p<0.001).