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台灣地區老人居住狀態與存活率的相關性探討

Association Between Living Arrangements and Survival among Taiwanese Elderly

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研究目的：國人平均餘命的延長，結婚率、生育率的下降，使得人口結構產生了變化，民國82年底，我國65歲以上的老年人口佔總人口之7.1%，已達WHO所定義之高齡化社會。國民健康局「台灣老人十年間居住、工作與健康狀況的改變」發現，民國78年至88年的十年間，獨居老人比例不變，但僅與配偶同住的明顯增加，與已婚子女同住的則巨幅減少。可見我國除了步入高齡化社會以外，老人的居住狀態也有了改變。本研究要探討的是台灣地區老人居住狀態與存活率之間的相關性。

研究方法：以國健局「中老年身心社會生活狀況長期追蹤」民國82、85、88、92、96年，共五波的調查為資料庫，將居住狀態分為四組：獨居、僅與配偶同住且配偶健康情形不好、僅與配偶同住且配偶健康情形良好、其它，使用SPSS 15.0 for Windows統計軟體，以time-dependent Cox proportional hazard model探討老人的居住狀態與長期追蹤的存活率，兩者之間的相關性。

結果：民國82年的資料庫，共有64歲以上的中老年人3141名，其中獨居315名、僅與配偶同住且配偶健康情形不好169名、僅與配偶同住且配偶健康情形良好332名，IADL失能的平均項目數分別為0.62、0.62、0.36(p=0.007)，ADL失能的平均項目數分別為0.11、0.04、0.05(p=0.251)，追蹤調查至民國96年，三組的中位數存活時間(median survival time)分別為125個月、145個月、166個月(p of log-rank test<0.001)。使用generalized estimating equation(GEE)比較各組居住狀態在一年內住院天數的差異，發現獨居的住院天數，為僅與配偶同住且配偶健康情形良好的1.53倍(p=0.027)。一年內是否曾看急診的分析發現，其它組較獨居組有更高的急診機會，勝算比為1.365倍(p=0.003)。

結論：民國82年的IADL失能項目數以獨居和配偶健康不好這兩組較高，ADL失能項目數則沒有顯著差異。追蹤至民國96年發現，獨居組的中位數存活時間最短，達顯著差異。而且獨居組的住院天數較長、急診使用機會較少，可能因獨居老人就醫不便，錯失治療黃金時間，疾病嚴重時才就醫，造成住院天數延長。居住狀態與存活率的關係，若加入social support、comorbidity等變項分析，是否獨居組的存活時間仍最短，值得後續的研究。獨居、僅與配偶同住是目前國內中老年人居住狀態改變的趨勢，希望有關單位適時的關懷與適當的轉介，可以改善目前獨居者存活時間最短的現象。

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冠狀動脈鈣化指數和心肌缺氧指數與心臟風險指數之相關性

Association of Coronary Artery Calcium Scores and Myocardial Perfusion Scores with Framingham Coronary Heart Disease (2-year) Risk

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Background/Aim：Heart disease is the leading cause of death worldwide. Risk of coronary artery disease (CAD) has traditionally been estimated with the Framingham Risk Score (FRS). Noninvasive cardiovascular imaging such as multi-detector computed tomography (MDCT) and myocardial perfusion imaging (MPI) may enhance efforts for early detection and appropriate intervention.

We aimed to compare MDCT and MPI with FRS (2-year) in hopes to elude whether such imaging tools are clinically useful in primary prevention of heart disease.

Methods: We retrospectively identified individuals who received both cardiac 64-MDCT and MPI as part of their health examination at a Central Taiwan tertiary hospital from January 2008 to December 2009. FRS (2-year) was calculated based on collected basic data and biomarkers. Coronary artery calcium (CAC) scores were obtained from MDCT studies. Perfusion scores were obtained from MPI studies.

Data were analyzed using SAS v9.2. Wilcoxon rank sums test, chi-square test, Fisher's exact test were utilized to compare FRS with basic characteristics and CAC scores, with $p<0.05$ representing statistical significance. Univariate and multivariate logistic regression analysis were used to compared CAC scores, MPI scores, and FRS.

Results: A total of 68 subjects were included, with 48 males and 20 females. Average age in years was 62.0±11.0. Subjects with FRS ≥2% (designated as high risk; n=49) had significantly higher age, higher systolic blood pressure (SBP), lower high-density lipoprotein cholesterol (HDL-C), and higher CAC scores than those with FRS <2% (designated as low risk; n=19) ($p<0.05$). Active smoking was also found to be significant for FRS ≥2% ($p<0.05$). CAC score was found to be correlated with increased FRS (2-year) (OR 4.06; 95% CI 1.26, 13.07). Perfusion scores obtained via MPI include the summed stress score (SSS), summed rest score (SRS), and summed difference score (SDS; defined as SSS minus SRS); SSS, SRS, SDS were found to have no statistical correlation with FRS. Comparison of a combination of CAC score and perfusion scores with FRS revealed that 1) CAC ≥117 with SSS <4 or SSS≥4, 2)