

WRITTEN STATEMENT:

Testimony and Statement for the Record for

Atique A. Mirza, M.D.

**Assistant Professor of Clinical Medicine, University of Connecticut Farmington Connecticut.
Consultant Cardiologist, Saint Francis Hospital and Medical Center, Hartford Connecticut**

**Hearing on H.B. No. 6002
Session Year 2007**

"Before the Joint Committee on Government Administration and Elections"

**March 16th, 2007
Legislative Office Building
Hartford, CT 06106**

Honorable Chairperson Slossberg and Chairperson Caruso, Vice Chairperson Meyer and Vice Chairperson Urban and honorable members of the Government Administration and Elections Committee, thank you for allowing me to testify and show my support to the H.B. 6002.

My name is Atique Mirza and I am a resident of the town of Avon. I am a physician in the community with specialization in Internal Medicine and Cardiovascular Medicine. I have a special training in multinational population based clinical trials and non-invasive cardiology from Brigham and Women Hospital, Harvard Medical School. I have been serving in Connecticut for almost five years.

My special interest and training in multinational population based clinical trials helped me to learn the impact of the cardiovascular disease all over the world. Coronary artery disease (CAD) is the number one killer in developed nations. Cardiovascular disease was responsible for 16.7 million deaths in the year 2003 globally; 7.2 million deaths were due to ischemic heart disease. While death rates of CAD have been declining over past three decades for the population as a whole, a disturbing trend has been noted among the persons of south Asian origin. Multiple studies on its prevalence indicate that the immigrant South Asian experience a disproportionately larger burden of CAD, and are at two- to three-fold higher risk of mortality compared with native population. Prevalence of risk factors including hypertension, dyslipidemia, central obesity, and diabetes, is not only higher in this

sub population, but is also rapidly rising. This predisposition to accelerated atherosclerosis seems to have genetic predisposition but is being enhanced by changing lifestyle, dietary and cultural preferences, and suboptimal application of the healthcare. The Study of Health Assessment and Risk in Ethnic (SHARE) group South Asians, a study done in Canada showed the highest rates of Diabetes Mellitus, highest total cholesterol, LDL (bad cholesterol) and Triglycerides and the lowest HDL-C (good cholesterol). *Rist et al* found the prevalence of DM in Pakistanis to be approximately three times that of the Europeans. In England, mortality from heart disease was approximately three times higher in diabetic men and women born in South Asia, as compared to those diabetics who were born in England and Wales. The SHARE study also showed the prevalence of CAD in-migrant Indians to be as compared to 4.9 % in Europeans. An analysis of 1.2 million deaths from 1979 to 1993, done in Canada showed that the proportional mortality from IHD was higher in Canadian men and women of from IHD was higher in Canadian men and women of South Asian descent (42% and 29% respectively) as compared to men and women of European (29% and 19%) descent.

McKeigue et al studied association of risk factors with early onset of CAD in Indians, and found that the incidence of CAD in Indians was higher and the earlier onset because of insulin resistance. In the INTERHEART study, *Yusuf et al* found that the mean age of presentation with a new myocardial infarction was 52 years for South Asians, as compared to 62 years for Europeans. 9.7 % percent of these cases were in people younger than 40 years of age.

It happened a few weeks ago when a 32year-old Pakistani gentleman came to see me for chest pain and was found to have significant coronary artery disease and ended up getting bypass surgery due to the complex nature of the disease. Unfortunately, the propensity to develop CAD generally tends to manifest early, and follows a malignant course. It afflicts individuals during the most productive years of their lives and leads to a significant loss of disability-adjusted life-years (DALY). Since the South Asian minority population is not significantly represented in major clinical trials, evidence-based management strategies for treatment and prevention of CAD are seriously lacking.

South Asians have a higher waist to hip ratio (WHR) for a given body mass index (BMI) as compared to Europeans and Americans because they have a tendency to accumulate abdominal fat instead of developing generalized obesity. Therefore, South Asians might not be considered obese by the WHO criterion, despite having high levels of abdominal fat. A recent report by the steering committee of the Western Pacific region of the WHO has suggested that the cut offs for overweight over weight and obesity be decreased to BMI values of 23 and 25 respectively for Asians. They also recommended decreasing the appropriate waist circumference for Asians to 90 cm in men and 80 cm in women. If this cut off were to be applied to the South Asian population, number of people meeting the criterion of metabolic syndrome (a cluster of high cholesterol, Diabetes, obesity) would increase even further.

This should give you a very brief synopsis of the unique and different aspect of the some of healthcare issues that impact the Asian Pacific American Communities with respect to diseases, education regarding prevention and management of the diseases. The importance of the availability and access to care cannot be emphasized enough. I feel strongly that real situation of the affair is even worse than what has been described, which require an emergent methodological approach in to identify, prevent and manage these healthcare issues to remove healthcare disparities.