



**Testimony and Statement for the Record by**

**Atique A. Mirza, M.D., F.A.C.C.**

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

**Before the Appropriations Committee at  
Legislative Office Building  
Hartford, CT 06106**

**Asian Pacific American Affairs Commission**

**FY 2010 & FY 2011  
February 11, 2009**

My name is Atique Azam 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 diseases. I also chair the health advisory committee of the Asian Pacific American Affairs Coalition of Connecticut. I have a special training in multinational population based clinical trials and cardiology from Brigham and Women Hospital, Harvard Medical School. I received my clinical cardiology training at the University of Connecticut and Saint Francis Hospital. I have been serving in Connecticut community for almost five years. I represent one of the fastest-growing and most diverse populations in the state of Connecticut and United States.

Asian Americans represent a wide variety of languages, dialects, and cultures as different from one another as from non-Asian groups. Asian Americans have historically been overlooked due to the “myth of the model minority”: the erroneous notion that Asian Americans are passive, compliant, and without problems or needs. The effects of this myth have been the failure to take seriously the very real concerns of this population. Asian Americans represent both extremes of socioeconomic and health indices: while more than a million Asian Americans live at or below the federal poverty level. Asian-American women have the highest life expectancy of any other group. Asian Americans suffer disproportionately from cancer, heart disease, stroke, hepatitis, tuberculosis, unintentional injuries (accidents), and diabetes. Factors contributing to poor health outcomes for Asian Americans include language and cultural barriers, stigma associated with certain conditions, and lack of health insurance.

While Asian Americans have the highest proportion of college graduates of any race or ethnic group (44.1% of Asian Americans have a bachelor's degree, compared with 24.4% of the total population) they contend with numerous factors, which may threaten their health. Some negative factors are infrequent medical visits due to the fear of deportation, no access to primary preventive health services and the lack of health insurance. Asian Americans also have a high prevalence of and risk profile for coronary artery disease, cerebrovascular accidents, chronic obstructive pulmonary disease, hepatitis B, HIV/AIDS, smoking, tuberculosis, and liver disease.

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. While death rates of CAD have been declining over the past three decades for the population as a whole in USA, a disturbing trend of increased incidence of this has been noticed among the people of south Asian origin. Multiple studies on its prevalence indicate that the immigrant South Asian Americans 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 applications of the healthcare.

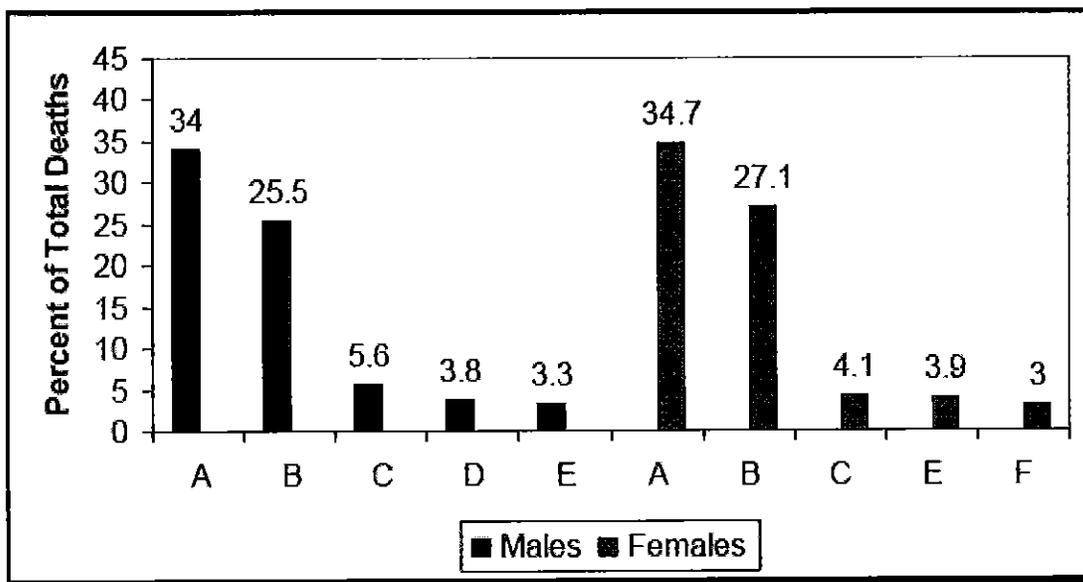
South Asians have a higher waist to hip ratio (WHR) for a given body mass index (BMI) as compared to Europeans and Americans because they have a tendency to accumulate abdominal fat instead of developing generalized obesity. Therefore, South Asians might not be considered obese by the WHO criterion, 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 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 37 inches in men and 33 inches 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.

*McKeigue et al* studied the association of risk factors with early onset of CAD in Indians, and found that the incidence of CAD in Indians was higher at an earlier age 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.

On the forefront of the medical care I see these health issues on daily basis. It happened recently that a 32-year-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.

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 health care cannot be emphasized enough. I feel strongly that real situation of the affair is even worse than what has been described, which requires an emergent methodological approach to identify, prevent and manage these healthcare issues to remove healthcare disparities.

**Figure 1. Leading Causes of Death for Asian/Pacific Islander Males and Females**



Source: *NGHS and NHLBI.*

A, Diseases of the heart and stroke; B, cancer; C, accidents; D, chronic lower respiratory disease; E, diabetes mellitus; F, influenza and pneumonia.

Honorable committee members, I am looking forward to your support for the funding of The Asian Pacific American Commission in Connecticut. This commission will help the Asian Pacific Americans by resolving the health care disparities and improve their socioeconomic, mental and physical well being. Thank you for your consideration of my testimony. I can be contacted for any further comments at (860) 670-2999 or e-mail [atique@yahoo.com](mailto:atique@yahoo.com).

