at entry. Risk estimates (RR, HR, OR) from models with the highest degree of multivariate adjustment in each study were transformed to a standardised top-vs-bottom fifth estimate according to the population’s baseline distribution of each nutrient’s values. We used the $I^2$ statistic to measure heterogeneity between studies and calculated pooled risk estimates for incident diabetes with random-effects meta-analysis.

**Results** Ten prospective cohort studies with data on 420,840 participants and 115,171 incident diabetes events were included. Highest to lowest fifth of intake of sucrose was associated with a 15% lower risk of diabetes (RR: 0.85, 95% CI 0.75 to 0.97). Other carbohydrate subtypes were not significantly associated with diabetes risk.

**Conclusion** All studies reported risk estimates adjusted for total energy intake and thus model an iso-energetic diet. Lower risk of diabetes associated with higher intake of sucrose is most likely to reflect the effect of substitution of sucrose for other nutrients rather than net increased intake of sucrose itself. Nutrient substitution patterns require further investigation.

**P2-5** VARIABILITY IN THE CONTROL OF CHRONIC PATIENTS IN PRIMARY CAREACCOORDING TO THE ELECTRONIC CLINICAL RECORD
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**Introduction** This study aims to describe the variability in Primary Care to comply with the good practice requirements (GPR) for the management of the following chronic conditions: Hypertension, hypercholesterolaemia, diabetes, alcohol abuse, COPD, depression, dementia, anxiety, asthma and obesity.

**Methods** The electronic clinical records of all general practitioners (1685; 2,147,754 professionals) of Osakidetza/Basque Health Service were examined. The rate of compliance of each of the GPR considered by the Health Plan of Basque Autonomous Community of Spain, standardised by age and sex, was calculated, as well as the variability statistics: extremal quotient (EQ$_{95}$), coefficient of variation (CV$_{95}$) and systematic component of variation (SCV$_{95}$).

**Results** The electronic records show that more than half of the patients are correctly controlled in nine out of the 44 GPR studied. On the contrary, in 16 GPR the compliance rate is lower than net increased intake of sucrose itself. Nutrient substitution patterns require further investigation.

**P2-7** MORTALITY AND CARDIOVASCULAR EVENTS IN PATIENTS UNDER TREATMENT WITH CLOPIDOGREL AND OMEPRAZOLE
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**Introduction** In 2009, it was announced that clopidogrel should not be taken with proton pump inhibitors. Omeprazole possibly reduces antiplatelet effect of clopidogrel. We compared mortality and cardiovascular rates between patients that had been treated with clopidogrel alone and those with both clopidogrel and omeprazole.

**Methods** A retrospective dynamic cohort study using secondary data of a health information system from a Health Maintenance Organization in Buenos Aires was analysed. Patients older than 17 years with purchase record of clopidogrel were followed for all-cause mortality and cardiovascular events (CE) from 1 January 2004 to 31 December 2008. Rates and 95% CIs are expressed per 1000 persons-year. Cox regression was used to obtain adjusted HRs for the risk of all-cause mortality and CE in groups exposed and unexposed concomitant to omeprazole at baseline.

**Results** Mean follow-up 13 months, 2518 patients received clopidogrel from whom 17.31% also received omeprazole. Exposed and unexposed to omeprazole were similar in sex (male 60%), age (mean 65) and comorbidities. The CE rate was 32.4 (95% CI 27.3 to 38.4) and 26.1 (95% CI 24.1 to 28.4) for each group respectively (RR 1.23 (p = 0.026) and adjusted RR 1.15 (p = 0.034)). The all-cause mortality rate was 68 (95% CI 57.4 to 80.8) and 52.3 (95% CI 48.1 to 57.5) for each group respectively (RR 1.23 (p = 0.026) and adjusted RR 1.15 (p = 0.034)).