that included probing depth (PD) and clinical attachment level (NIC) DCVI and was represented by one of the following outcomes: Coronary Artery Disease (CAD), Myocardial Infarction (AMI) with or without angina pectoris, or Acute Coronary Syndrome (ACS). The quality of the articles was assessed using criteria recommended in “The Strengthening the Reporting of Observational Studies in Epidemiology-STROBE”. In addition, compliance with the guidelines of the guide to meta-analysis for observational studies-MOOSE.

**Methods**

This cross-sectional study was conducted among residence of age 40 and over, living at the Park Health Center Area in Ankara-Turkey. Three hundred participants from the eligible population (n=5962) were chosen by simple random sampling of these 260 (36.6%) were reached. Twenty questions for sociodemographic factors and chronic diseases and short form SF-36 health survey questionnaires had been administered to each participant. Data analysis was performed by using SPSS for Windows program, Mann–Whitney U, Kruskal–Wallis and multiple linear regression tests were used for statistical analysis.

**Results**

The mean of general SF-36 score of the study group was 61.8±21.9 (95% CI 59.1 to 64.5). The scores for physical functioning, physical role, bodily pain, general health, vitality, social functioning, emotional role and general mental health scales were (70.5), (57.8), (64.5), (54.6), (52.8), (77.9), (56.7), and (59.8) respectively. In multiple linear regression analysis; age, sex, education, type of house, annual income per capita, hypertension and the other chronic diseases had significant effect on various scales of the SF-36.

**Conclusion**

The SF-36 scores of the study population were found to be low. It was determined that older age, female sex; low education level, hypertension and other chronic diseases have a negative effect on quality of life. According to results multidisciplinary approach and efforts are necessary for promoting quality of life.

However, increasing BO incidence may also simply reflect changes in endoscopy practices together with improvement in disease recognition. The aim of our investigation was to assess BO incidence over a 13-year period using a population-based register in Northern Ireland.

**Methods**

The Northern Ireland Barrett’s oesophagus Register is a population-based register of all adults diagnosed with BO, defined as columnar epithelium of the oesophagus, in Northern Ireland between 1993 and 2005. Annual BO incidence rates were calculated per 100 000 of the population, per 100 upper gastro-intestinal endoscopies and per 100 oesophageal biopsies performed in Northern Ireland.

**Results**

During the 13-year period, 197 655 patients underwent an endoscopy and 9 529 of these were diagnosed with BO. Average annual BO incidence rates rose by 2.5-fold, increasing from 31.9/100 000 during 1993–1997 to 80.1/100 000 during 2002–2005. Over the same time, there were 1.5- and 1.6-fold increases in endoscopy and biopsy rates in the population, respectively. Even with increasing rates of endoscopy and biopsy, BO was still diagnosed more frequently per 100 endoscopies and per 100 biopsies.

**Conclusion**

BO incidence rates in Northern Ireland have increased more rapidly than the rate of endoscopies or biopsies. This could indicate that a true rise in BO incidence has occurred, contributing to the increase in OAC seen in Western populations.

**References**

1. Öuger, 2M Çal, 3Ministry of Health, Ankara, Turkey, Turkey, 2Ankara University Medical Faculty, Ankara, Turkey, Turkey

**Introduction**

This study has been planned to determine quality of life of people in one health center area, and the effect of sociodemographic factors, hypertension and other chronic diseases.

**Methods**

The Northern Ireland Barrett’s oesophagus Register was represented by one of the following outcomes: Pre-cursor condition for OAC, may explain this phenomenon.