**Methods**  400 addicts were recruited from methadone clinics in 2009–2010. A self-designed questionnaire with excellent reliability was used to determine those with and without high risk behaviours. ORs with 95% CIs were estimated by logistic regression. Ethics approval was obtained from Tehran University.

**Results**  There was significant difference between the two study groups (with and without high risk behaviours) in economic status, drug type, administration route, age, and drug abuse onset age. Education level was significantly lower in women. One quarter experienced homeless, 62% had no support from any insurance or supportive organisations, only 26% had constant employment and over 50% had prison history. 12.5% were injection users and 14% shared syringes. One quarter reported high risk sexual behaviour and 69.4% had not used condoms in last their last sex encounter (significantly lower in women). A decrease of one year in age was associated with decreased drug use onset age and increased sexual risk behaviours by 6% (AOR = 0.94, 95% CI 0.91 to 0.98) and 10% (AOR = 0.91, 95% CI 0.85 to 0.97) respectively. Poor economic status reduced risk sexual behaviour (AOR = 0.35, 95% CI 0.15 to 0.96). Prison history increased injection behaviour more than twice (AOR = 2.89, 95% CI 1.4 to 5.95).

**Conclusions**  These findings illustrate that interventions are needed in young heroin users even in those with a good economic state.

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**P2-259**  EVALUATION OF THE EFFECTIVENESS OF THE PHARMACOTHERAPY FOLLOW-UP ON THE TREATMENT OF HYPERTENSIVE PATIENTS: A COHORT STUDY

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**Introduction**  The control rate of hypertension in the population is fair. Pharmaceutical Care is a recent approach, seeking to magnify therapeutic results.

**Objective**  To evaluate the effectiveness of the pharmacotherapy follow-up conducted by the Pharmacist on hypertension management.

**Methods**  The study is a historical cohort with a dynamic population of patients referred to an outpatient hypertension clinic. Patients were followed for 12 months. Those difficult-to-control referred by the physician to pharmacotherapy follow-up were compared with patients under conventional treatment. Endpoints included blood pressure (BP) variation and the rate of control (<140/90 mm Hg). General Linear Model, modified Poisson Regression, and segmented regression were used in the data analysis.

**Results**  Of 993 patients, 150 were referred for pharmacotherapy follow-up. Patients in the pharmacotherapy follow-up were older, with lower education level, longer diagnoses of hypertension and significantly higher levels of BP. The deltas of SBP were 7.4±1.9 vs 10.5±0.8 mm Hg (p=0.16) and diastolic 6.7±1.0 mm Hg vs 5.9±0.4 (p=0.48) for pharmacotherapy follow-up and conventional treatment groups, respectively, adjusted for initial pressure. The control rate was 45.3%, being 28.1% in the exposed and 48.6% in the unexposed (p<0.001). Comparing the BP of the same patients before and after exposure to pharmacotherapy follow-up showed a change in the trend of SBP and DBP (p<0.001).

**Conclusion**  Hypertensive patient difficult-to-control under pharmacotherapy follow-up showed a reduction in BP similar to patients who received only conventional treatment. The study suggests that pharmacotherapy follow-up is effective in the management of selected hypertensive patients.

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**P2-260**  POPULATION-BASED PREVALENCE OF DUCHENNE/BECKER MUSCULAR DYSTROPHY (DBMD) IN THE USA

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**Introduction**  DBMD has an estimated prevalence of 1/5500 male births. Worldwide, this estimate varies, likely due to differences in diagnostic criteria, ascertainment, and survival. To date, no U.S. population-based DBMD prevalence data by race/ethnicity have been published.

**Methods**  In 2002, the Centers for Disease Control and Prevention established the MD STARnet to conduct population-based DBMD surveillance in four U.S. sites. Each site conducts active surveillance to identify males with DBMD born since January 1992. Using these data, we calculated DBMD prevalence by race/ethnic subgroups and birth intervals (1986–1990, 1991–1995, 1996–2000). Prevalence was calculated as: [number of DBMD males age 5–9 years/number of male residents, age 5–9 years]. With the average age at DBMD diagnosis of 2 years, the estimated numbers of patients were annualized to 5 years after birth. Race/ethnic subgroups were defined by the MD STARnet to include non-Hispanic white, non-Hispanic black, Hispanic, and Asian/Pacific Islander; the latter two were combined due to small sample size for DBMD. For this analysis, the entire U.S. population was estimated using birth cohort data from the National Center for Health Statistics. The period prevalence was calculated using the telephone follow-up method by the MD STARnet to ensure maximum ascertainment of males with DBMD.

**Results**  The period prevalence was 1.57 per 100,000 males. The estimated population-based DBMD prevalence by race/ethnicity was 1.85 per 100,000 males among non-Hispanic white males, 1.52 per 100,000 males among non-Hispanic black males, 1.27 per 100,000 males among Hispanic males, and 0.93 per 100,000 males among Asian/Pacific Islander males. The overall prevalence of DBMD among males born in the U.S. from 1986 to 2006 was 1.64 per 100,000 males, with an increasing trend over time (p<0.001). The overall prevalence of DBMD among males born in the U.S. from 1986 to 2006 was 1.64 per 100,000 males, with an increasing trend over time (p<0.001).