Background ‘Time preference’ is an economic concept that describes the trade-offs that individuals make between costs and benefits occurring at different points of time. Related psychological concepts include time perspective, impulsivity and delay of gratification. Present orientated people prefer immediate over future gains and place more value on these. Differences in how much value different individuals place on future outcomes are likely to play some role in present day behavioural decisions.

There is substantial cross-sectional evidence that smokers tend to have shorter term time preferences than non-smokers. However, few studies have explored the longitudinal relationship between time preference and smoking cessation.

We explored the relationship between time preference and smoking cessation in a general adult cohort using data from a large Australian longitudinal panel study: the Household Income and Labour Dynamics of Australia (HILDA) survey.

Methods HILDA is a longitudinal, nationally representative, household survey which began in 2001. The focus of the survey is on economic and subjective well-being, and labour market and family dynamics. Data is collected by annual interview and self-complete questionnaire.

Members of the HILDA panel, aged 15–64, who responded to at least four waves of data collection between 2001 and 2008, and reported any level of tobacco consumption at any wave were included in the analyses.

Smoking cessation was measured using self-report questions. Time preference was measured using self-reported time period for financial planning. A range of sociodemographic (age, number of children, various markers of socio-economic position) and smoking-related (previous quit attempts, years smoked) co-variates were controlled for.

Results 1,817 individuals (representing 7,913 unique observations) were included in the analyses. In univariable analyses, both men and women who reported quitting smoking were more likely to have a longer term time preference in the data collection period immediately prior to quitting than those who did not quit (men: t(4,126)=4.59, p<0.001; women: t(3,783)=7.18, p<0.001). These relationships persisted after control for socio-demographic and smoking-related covariates (hazard ratio of quitting in those with longer vs shorter term time preference (95% confidence intervals) = 1.27 (1.03 – 1.57) in men; 1.31 (1.05 – 1.63) in women).

Conclusion Adult smokers with a longer term time preference are more likely to quit smoking. This does not exclude the possibility that quitting smoking simultaneously leads to development of longer term time preference. Interventions that encourage development of longer term time preference may enable smoking cessation.
adjusted odds ratio (OR) = 0.62, 95% CI: 0.52 to 0.74) and a lower proportion of survived one year (43%, v 27%, OR=0.78, 0.68 to 0.89). Urgency of GP referral did not affect treatment intent or survival. Routes to diagnosis varied across the 30 cancer networks, with the proportion of patients diagnosed after emergency admission ranging from 8.7% to 32.3%.

Conclusion Outcomes for cancer patients are worse if diagnosed after emergency admission. Networks should examine the causes of large regional variations to reduce rates of diagnosis after emergency admission.

PS38 SARCOGENIC OBESITY AND RISK OF ALL-CAUSE AND CARDIOVASCULAR MORTALITY IN OLDER MEN

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Background Sarcopenic obesity refers to the age-associated loss of muscle mass coupled with high adiposity levels. Although it is known that both obesity and low muscle mass are associated with increased mortality, few studies to date have examined the combined effects of sarcopenia and obesity on all-cause or cardiovascular mortality. We examined the relationship between sarcopenic obesity and all-cause and cardiovascular mortality in older men.

Methods 4,252 men from the British Regional Heart Study, aged 60–79 years in 1998–2000, were followed prospectively until 2011 for mortality. At baseline, midarm muscle circumference (MAMC) measurement was used to provide information on muscle mass and measurement of bioelectrical impedance analysis (BIA) to provide fat free mass index. Obesity was assessed by measurement of body mass index (BMI), waist circumference (WC), and BIA (providing fat mass, FM, index). Participants were classified as either normal, sarcopenic, obese, or sarcopenic obese using varying measures of adiposity and muscle mass, since no consensus definition for sarcopenic obesity exists. Associations between the four sarcopenic obesity groups and mortality rates (all-cause and cardiovascular) were examined using Cox regression, adjusting for age, smoking, alcohol intake, social class and physical activity.

Results There were 1,456 deaths during follow-up (mean=10.1years), 578 (40%) of which were cardiovascular. Obesity (assessed by BMI, WC and FM index) was not significantly associated with all-cause mortality, but BMI and WC were significantly associated with cardiovascular mortality (p<0.05). Low muscle mass (MAMC only) was significantly associated with all-cause mortality (p<0.001) but not with cardiovascular mortality. Sarcopenic obese men (MAMC ≥24.95cm; WC>102cm) had the greatest relative risk of all-cause mortality (RR: 1.66, 95% CI:1.23–2.25). Risks of all-cause mortality were also increased among men who were sarcopenic obese only (RR: 1.28, 95% CI:1.09–1.45) and obese only (RR:1.44, 95% CI:1.25–1.64) compared with normal men. Similar, though weaker, relationships were seen using MAMC and BMI to define sarcopenic obesity, but not when using combined BIA measures. Sarcopenic obese men had a less marked excess cardiovascular mortality risk (RR: 1.20, 95% CI:0.69–2.08), compared with obese men (RR: 1.35, 95% CI:1.09–1.67).

Conclusion Sarcopenic obese older men are at an increased risk of all-cause mortality compared with those with only sarcopenia or obesity or normal body composition. MAMC and WC appeared to be the best markers of muscle mass and obesity for predicting all-cause mortality, compared with BMI and BIA measures. The added effect of sarcopenia and obesity, however, did not have a synergistic effect on cardiovascular mortality. Efforts to promote healthy ageing in the elderly should focus on both preventing obesity and maintaining muscle mass.