

dence interval, 1.06-5.15), presence of Methicillin-resistant *Staphylococcus aureus* (MRSA) (odds ratio, 5.51; 95% confidence interval, 1.43-21.25), renal insufficiency before debridement (odds ratio, 4.46; 95% confidence interval, 1.36-14.56), clinical status score (including mechanical ventilation required still on day 3 and/or amines required in ICU after debridement) (odds ratio, 29.03; 95% confidence interval, 11.26-74.82)

**Conclusions:** Pathogens are one of the major factors of post-operative mediastinitis mortality. GNB as MRSA are associated with high mortality. These results emphasize the importance of antimicrobial prophylaxis with a large spectrum as second generation cephalosporin.

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#### Incidence and risk factors of contrast-induced nephropathy after coronarography

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The incidence of contrast-induced nephropathy (CIN) is variably estimated among studies. CIN is associated with increased morbi-mortality.

**Aim:** To determine the incidence of CIN and to identify its risk factors.

**Methods and population:** In this cohort study, 1800 consecutive patients (age=58.9±11.1years [30-84], 62.8% males, 41.1% diabetics, and 22.8% with creatinine clearance < 60 ml/min) with various diagnoses had a coronarography investigation and were prospectively enrolled. CIN was defined by an acute impairment of the renal function occurring within 3 days after contrast media administration in the absence of an alternative etiology with an elevation of the serum creatinine level by 0.5 mg/dl or 25%. The incidence of CIN was 17.2%. Factors related to CIN were: Age>60 years, diabetes, creatinine clearance < 80 ml/min, emergency investigation, left ventricular ejection fraction (LVEF) < 45%, multi-vessel coronary lesions or lesion of left main coronary artery, per-procedural hypotension (systolic pressure < 80mmHg), treatment with furosemide or antispirinolactone diuretics and volume of injected contrast media (CMV) > 90ml. In a multivariate step wise model, 5 independent risk factors of CIN were identified: per-procedural hypotension (hazard ratio (HR)=3.99, CI95% [1.65-9.66], p=0.002), creatinine clearance <80ml/min (HR=2.87, CI95% [1.59-5.19], p<0.001), diabetes (HR=2.26, CI95% [1.29-3.98], p=0.005), LVEF<45% (HR=2.03, CI95% [1.22-3.39], p=0.007), and CMV >90ml (HR=1.72, CI95% [0.99-2.99], p=0.054). Age is related to creatinine clearance and increases the risk of CIN through this factor. Renal insufficiency and diabetes are mutually enhancing factors for CIN. 93% of our patients recover normal renal function within 15 days. 2 deaths and 2 terminal renal insufficiencies were noted in patients with CIN within 3 months of follow-up.

**Conclusion:** Delimitating a target population with risk factors of CIN is a key step for its prevention.

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#### Thrombolytic therapy in pulmonary embolism

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**Introduction:** Pulmonary embolism (PE) is a relatively common cardiovascular emergency. PE is a difficult diagnosis that may be missed because of non-specific clinical presentation. Non invasive investigations are compulsory to confirm PE. The management of PE is now well codified especially massive PE.

**Observations:** 2 women aged respectively of 28 and 34 years, hospitalized in our hospital for massive pulmonary embolism with poor hemodynamic state. For the first patient the diagnosis is confirmed by TTE showing thrombus in the right atrium and left pulmonary artery and by computed

tomography angiography. The two patients received thrombolytic treatment by recombinant tissue plasminogen activator (rtPA) with favorable outcome.

**Conclusion:** Thrombolytic therapy is the first-line treatment in patients with high-risk PE presenting with cardiogenic shock and/or persistent arterial hypotension, with very few absolute contraindications.

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#### Infective endocarditis and high degree auriculo-ventricular block

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**Introduction:** Auriculoventricular block (AVB) during infectious endocarditis is a serious complication. The aim of our study is to determine the impact, the evolutive profile of infectious endocarditis complicated of AVB.

**Patients and methods:** we enrolled a retrospective study of 225 cases admitted for infectious endocarditis. High degree AVB include AVB 2nd Degree and third degree.

**Results:** 44 patient (Group A) developed high degree AVB during the evolution or at the time of the diagnosis (19,55%). other cases constitute Group B. there was not a difference concerning the sex, the presence of diabetes or of the renal insufficiency. Patients of groupe A were statistically older. The Aortic regurgitation was more frequent in groupe A (A=33,33%, B=16,2%, p<0,001). Besides echocardiographic data was more serious at the group A, notably by the frequency of the annular abscess (A=37,5%; B=18,42%, p=0,009), myocardial abscess (A=5% ;B=0%; p=0,003) and large size vegetation(>15mm) (A=18,18%; B=24,32%; p = 0,09). The presence of high degree AVB is more frequently complicated of cardiac failure (A=23%, B=11%, p=0,02). Besides, these anomalies of the conduction were one of major predictifs factors of mortality (A=50%, B=23%, p=0,028). Patients of group A needed more surgery than group B but without statistical difference (p=0,72).

**Conclusion:** AVB can occur during IE immediately or several days of a good conducted antibiotherapy. it's generally a sign of the severity and the extension of lesions. This complication is associated to a heavy mortality. Daily monitoring by ECG can detect this anomaly earlier and thus indicate surgical intervention at time.