

Abstract 0291 – Table: Predictive values

	Sensitivity	Specificity	Positive predictive value	Negative predictive value
hs-cTnT <14 ng/L and <50% change at 3 hours n=91	0.22 IC (0.028-0.6)	0.73 IC(0.604-0.83)	0.10 IC(0.012-0.317)	0.87 IC (0.755-0.947)
Copeptin <10 pmol/L + hs-cTnT <14 ng/L n=71	0.75 IC(0.428-0.945)	0.6 IC (0.476-0.715)	0.24 IC(0.118-0.412)	0.93 IC(0.817-0.986)
Copeptin<10 pmol/L + negative kinetic of hs-cTnT at 3 hours n=52	0.79 IC (0.4-0.972)	0.54 IC (0.418-0.669)	0.19 IC (0.08-0.352)	0.95 IC (0.823-0.994)

kinetic of hs-cTnT and a negative copeptin, only 2 (3.8%) had a critical stenosis (NPV 95%) both related to in stent restenosis (table 1).

Conclusion In patients with pre-existing CAD, once ACS is excluded, copeptin provides a useful additional triage strategy in acute chest pain to exclude severe coronary stenosis or stenosis inducing myocardial ischemia.

The author hereby declares no conflict of interest

0358**Diuretic treatment versus fluid expansion in acute normotensive pulmonary embolism**

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Background In submassive pulmonary embolism (PE), when a right ventricular (RV) dysfunction (RVD) is present, the benefit of fluid expansion (FE) is questionable. The Franck-Starling law suggests that the reduction of the RV overload may enhance the RV systolic function.

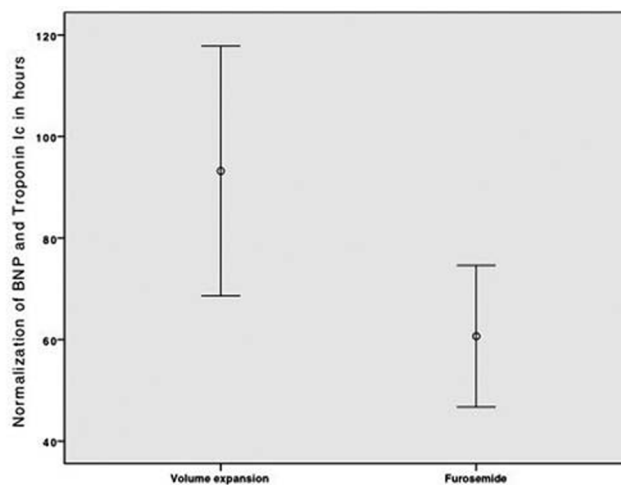
Purpose The aim of our study was to compare the effects of a diuretic treatment (DT) versus FE in patients hospitalized for normotensive PE with RVD.

Methods We performed a prospective study. Consecutive patients hospitalized for normotensive PE were treated with diuretic (40mg IV furosemide at admission) or FE (500cc of sodium chloride infusion during four hours at admission). The primary endpoint was the timing for normalization of BNP and troponin Ic values. The secondary endpoints were variations of clinical and RV echographic parameters.

Results Forty five patients were included. Timing for Troponin and BNP normalization was 60,7±28 hours in the DT versus 93,2±42 hours in the FE

group (figure 1, p=0.02). Normalization of RV dilatation took 91,7±14,2 hours in the DT group versus 108,4±17,5 hours in the FE group (p=0.01). Normalization of the RVD took 81,2±18 hours in the DT group versus 94,9±13,1 hours in the FE group (p=0.03).

Conclusion In the early management of normotensive PE with RVD, DT may be superior to FE in order to improve the time to normalization of biological and echocardiographic markers.



Abstract 0358 – Figure 1

The author hereby declares no conflict of interest