

At the end of ICU stay, success was present in 51 pts (71.8%). Median stay in the ICU after levosimendan administration was 4 [IQR:1-9] days. A beta-blocker and an ACE inhibitor were given in 43.1% and 74.5% respectively.

No clinical, biological or hemodynamic characteristics were predictive of failure to wean from inotropes with levosimendan. Overall, 13 pts (18%) died in the ICU and another 12 (17%) died after leaving the ICU during their hospital stay. Heart transplantation was performed in 16 patients within 6 months, 13 of them were in the success group. Failure to wean from inotropes within 48 hours of levosimendan administration was a strong predictor of in-hospital mortality (64% vs 27%; $p=0.01$).

Conclusions: In patients with advanced heart failure and dependant on dobutamine or milrinone, levosimendan is a valuable therapeutic option to wean these patients off intravenous inotropic support.

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Predictors of in hospital mortality in patients with refractory cardiogenic shock following acute myocardial infarction despite a patent infarct artery

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Objectives: We sought to evaluate the impact of post-primary percutaneous coronary intervention (PCI) patent artery in the infarct-related artery in patients with ST-segment elevation myocardial infarction (STEMI) and cardiogenic shock.

Background: Little is known about predictors of survival in patients with persistent shock following STEMI despite a patent infarct artery.

Methods: This retrospective monocentric study included consecutive patients with an early cardiogenic shock complicating STEMI from 2007 to 2010 in our center.

All these patients underwent early PCI: ie up to 36 h from symptoms and only patients with infarct artery patency defined as final TIMI 3 flow were included.

Results: Between 2007 and 2010, 832 patients underwent primary PCI for acute STEMI. We studied specifically a cohort of 84 patients with cardiogenic shock with post-procedure patent TIMI 3 infarct related artery.

The mean age of the patients was 64 ± 13 years. The delay between STEMI diagnosis and cardiogenic shock and open infarct related artery were 4.5 hours and 7 hours respectively.

95% of patients underwent revascularization of the culprit lesion and multistage PCI was performed in 7% of cases.

After PCI, mechanical ventilation was used in 80% of cases and all patients needed inotropes drugs. In two cases, a percutaneous ECMO support was decided.

The in-hospital mortality rate was 44%. In univariate analysis, pulmonary insufficiency characterized by ratio PaO₂/FIO₂ ($p=0.02$), increased serum creatinine (SCr) from baseline-25% ($p=0.01$) and level of lactates ($p<0.01$) were significantly associated with increased in hospital mortality.

In multivariate analysis, the ratio PaO₂/FIO₂ and an increased SCr were independent predictors of in hospital mortality.

At 6 months, the mortality rate was 46%. We noted a coronary revascularization in 6 cases, a implantable cardioverter-defibrillator in 3 cases and a left ventricular ejection fraction -35% in 20% of patients.

Conclusion: These prognostic variables may be useful for risk-stratification and in selecting patients for investigation of additional therapies

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Massive pulmonary embolism: clinical features, paraclinical findings and prognosis

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Introduction: Massive pulmonary embolism is defined as occlusion of more than 50% of the pulmonary vasculature or occlusion of two or more lobar arteries.

Purpose of work: Describe the clinical features, paraclinical findings and prognosis of patients with massive pulmonary embolism.

Materials and methods: It is a single-center study, retrospective, covering 145 patients hospitalized in the emergency department of the hospital Habib Thameur in the period from January 2000 to December 2007 with a pulmonary embolism. We divided our patients into 2 groups: one group with a massive pulmonary embolism (MPG+) and a group without (MPG-).

Results: The diagnosis of massive pulmonary embolism was retained in 23 patients that is 21.3%. no features patient's specificities (age, sex and underlying pulmonary defects) were significantly related to massive pulmonary embolism. Clinical examination showed that (MPG+) had a respiratory rate (RR) and heart rate (HR) significantly higher than the (MPG-) (average RR: 27 vs 23, $P=0.03$) (average HR: 104 vs. 95, $P=0.02$). The report PaO₂ / FIO₂ was significantly lower in the (MPG+) (304 vs. 358, $P=0.02$). The thoracic echocardiography was performed in 42 patients (8: MPG+ and 34: MPG-), the echocardiographic characteristics which were significantly associated with massive pulmonary embolism were: right ventricular dilation ($P=0.04$) and pulmonary artery hypertension ($P=0.0006$). Massive pulmonary embolism was not significantly related to hospital mortality.

Conclusion: Massive pulmonary embolism does not prejudice the outcome neither clinical consequences nor the prognostic for the patient.