Results The incidence of CVD from time spent sitting or standing still at work showed a U-shape relationship. >300-1200 and 1200-1800mins/week spent sitting or standing at work halved the risk of CVD HR: 0.63[0.42-0.94]; 0.48[0.31-0.76], respectively. The risk was higher for men who routinely carried heavy objects when their jobs involved little or no time spent sitting or standing still at work, although this risk was decreased for men who spent >300-1200mins/week sitting or standing still at work.

Conclusion The effects of occupational activities on CVD depend not only on the types of occupational tasks but also on the balance of activities at work and the potential compensatory effects of other activities. Cardiovascular prevention strategies should include a range of occupational physical activities.

The author hereby declares no conflict of interest

0308

Obstructive sleep apnea and acute coronary syndromes: comparison of clinical and angiographic characteristics

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Introduction Obstructive sleep apnea hypopnea syndrome (OSAHS) is associated with a range of cardiovascular diseases and increase cardiovascular mortality.

Aim The aim of this study was to compare the clinical and angiographic characteristics of patients admitted for acute coronary syndromes (ACS) with and without OSAHS.

Methods We examined the apnea hypopnea index (AHI) using polygraphy (PG) in 60 consecutive patients with ACS who underwent coronary angiography. OSAHS was defined by AHI ≥5 events per hour. The Friesinger score was calculated for each patient from the coronary angiography.

Results The average age of patients was 59.73 years±10.1 years. The sex ratio was 1.5. The distribution of risk factors was as follows: hypertension in 61.7% of cases, diabetes in 58.4% of cases, smoking in 51.7% of cases and dyslipidemia in 40% of cases. The mean body mass index (BMI) was 27.98kg/m^2. The average of ejection fraction was 54%±15.87.

61,7% of patients had an AHI≥5. There were no differences between patients having OSAHS and those without OSAHS regarding clinical and angiographic characteristics. The table summarizes these results.

Abstract 0308 – Table: Comparison of patients with and without OSAHS

	OSAHS n=37	No OSAHS n=23	P
Age	61,22±9,3	57,35±11,2	0,15
Male	35%	25%	0,51
BMI	27,94±3,93	28,05±4,04	0,92
Smoking	28,3%	23,3%	0,26
Hypertension	40%	21,7%	0,51
Ddiabetes	31,7%	26,7%	0,16
BMI	27,94±3,93	28,05±4,04	0,92
3 vessel disease (%)	21,7%	16,7	0,51
Friesinger score	8,6±4,8	8,65±5,44	0,97

Conclusion In conclusion, we noted a high incidence of OSAHS in ACS in our population. There is no difference between ACS patients with and without OSAHS. This latter doesn't seem related to the severity of the coronary disease. Further studies are needed to evaluate the impact of the presence of OSAHS on short and long term prognosis.

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0222

The information provided by the monitoring of recovery during a treadmill test

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Introduction The diagnosis of myocardial ischemia on exercise testing (ET) is typically based on ST segment during exercise and its recovery. However, according to recent studies attention should be paid on exercise capacity but also the heart rate profile, particularly its recovery in the first minute with a diagnostic and especially prognostic value. The importance of these variables is more pronounced in women posing positive diagnostic problem in the ET.

Methods This study included 350 women with type 2 diabetes (TD2), with mean age of 58.84 years. It consisted of practicing a maximum treadmill test (TT) according to the Bruce protocol.

Results After a positive TT, coronary angiography was proposed to135 cases. The results are in favor of a truly positive TT in 35 patients (25.62%), in 33.51% it is infiltrations and in 40.31% coronaries appear healthy. Univariate analyses according to the variables of the TT, the ones who have a statistically significant positive correlation, are: HRR 1' (p=0.008), the reservation of HR (HR max – HR rest) (p=0.02), and recovery time of ST depression (p=0.006). Multivariate analysis in confrontation with coronary angiography, those among others predicts significant coronary lesions: -amplitude ST segment (p=10^7 5) and its recovery time (p=0.08) -the HRC 1 '(p=0.02), the global recovery time (p=0.02). The prediction performance of coronary anomaly is 87.88%.

Conclusion Women in the interpretation of ST shift can lead to misinterpretation and necessitate the study of parameters which include those in recovery. This work by using exercise testing may therefore allow stratification of coronary risk and especially to avoid the practice of coronary angiography after weakly positive effort.

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0264

Short- and long-term prognosis of previous and new-onset atrial fibrillation in ST-segment elevation acute myocardial infarction in Algeria

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Introduction and objectives The impact of atrial fibrillation on the prognosis of myocardial infarction is still the subject of debate. We analyzed the influence of previous and new-onset atrial fibrillation on in-hospital and long-term prognosis in patients with acute myocardial infarction.

Methods Prospective study of 1265 patients with ST-segment elevation acute myocardial infarction (military hospitals of Algiers and Constantine). We studied all-cause in-hospital and long-term mortality (median 4.2 years) using adjusted models.

Results In total, 4.5% of patients had previous atrial fibrillation and 10.6% had new-onset atrial fibrillation. In general, both groups of patients had a high baseline risk profile and an increased likelihood of in-hospital complications. The crude in-hospital mortality rate was higher in patients with previous atrial fibrillation than in those with new-onset atrial fibrillation (22% vs 12%; P<.001; 30% vs 10%; P<.001). The long-term mortality rate was 11.11/100 patient-years in patients with previous atrial fibrillation and 5.35/100 patient years in those with new-onset atrial fibrillation (both groups, P<.001). New-onset fibrillation alone (odds ratio=1.55; 95% confidence interval, 1.08-2.22) was an independent predictor of in-hospital mortality. Previous atrial fibrillation (hazard ratio=1.24; 95% confidence interval, 0.94-1.64) and new-onset atrial fibrillation (hazard ratio=0.98; 95% confidence interval, 0.80-1.21) were not independent predictors of long-term mortality.

Conclusion New-onset atrial fibrillation during hospitalization is an independent risk factor for in-hospital mortality in acute myocardial infarction.

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