risk (0-2 points), medium risk (3-7) and high risk (>7 points). Univariate analysis was used for statistical analysis.

Results: At the inclusion 94 (65.4%) of our patients had had a low risk (TIMI between 0 and 2), 48 patients (32.3%) had had an intermediate risk (TIMI between 3 and 7) and 4 (2.2%) had had a high risk (TIMI between 8 and 14). Median TIMI risk score was 2.3 (ranging from 0 to 11). During follow-up there were 18 deaths (12.3%). Mortality was 5.7% in the low risk group, 25.6% in the intermediate risk group and 0% in the high risk group. Mortality increased significantly with TIMI risk score in patient with TIMI score < 7 (p=0.01). In patients with TIMI score > 8, our study did not allow us to draw any conclusions. We calculated Mortality predicted by corrected TIMI score (Mortality predicted at 1 year – Mortality predicted at 30 days). In patients with TIMI risk score <7, Mortality at 10 years of follow up was 4.4 more important than corrected mortality predicted at 1 year.

Conclusions: TIMI Risk Score accurately defines the population of STEMI patients who are at high risk of death not only during the first 30 days, but also during 10 years of follow-up. This simple score should be included in the discharge letters because it contains very useful information for further care.

0065

Validation and recalibration of the Framingham's score hard coronary heart disease in a coronary population

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Purpose: The aim of the study was to Validate and to recalibrate the Framingham's score Hard coronary heart disease (HCHD score) in a coronary Tunisian population.

Methods: Baseline data were collected between 1997 and 2004 in 146 patients. We excluded from the analysis all patients who died during the first 30 days of hospitalization. Vital status was checked and causes of death were obtained in 2011 after a mean follow up of 9.6 years. We also noticed myocardial infarction during the same period. The expected incidence of the composite event cardiovascular death and/or myocardial infarction was calculated by applying the HCHD equation on the basis of the level of risk factors in diabetic and non-diabetic populations and was compared with the observed incidence of the composite event in each group. Correction factor was calculated for each group. For the risk thresholds 20 % and that determined from the ROC curve of the HCHD score sensitivity, specificity values ??were calculated.

Results: The total number of patients who developed the composite event cardiovascular death and/or myocardial infarction was 34 (23.3%). The average of HCHD score in our population is 16.2 +/–7.2% with a range from 2 to 30%. The HCHD score is significantly associated with cardiovascular death event and/or myocardial infarction in our population (p = 0.029). The correction factor score is 2 in diabetic group, 1.1 in non-diabetics group and 1.4 for the total population. The relative risk of HCHD score is calculated to 1.59 for the composite event cardiovascular death and/or myocardial infarction at 10 years.For the risk threshold for 20%, sensitivity was calculated at 41.11% and specificity at 76.7%.

Conclusion: HCHD score is validated in coronary male Tunisian patients with and recalibrated using correction factors. Validation on a larger population and multi-ethnic remains our future desire.

0437

SYNTAX score is associated with in-hospital mortality as assessed by GRACE risk score in patients with acute myocardial infarction

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Background: Current guidelines for the management of patients with acute myocardial infarction (AMI) recommend the GRACE score for risk stratification with assessment of admission variables. The syntax score (SS) is a comprehensive angiographic scoring system that is derived entirely from the coronary anatomy and lesion characteristics. We investigated the relationship between severity of coronary artery disease (CAD) assessed with SYNTAX Score (SS) and GRACE Score (GS) in patients with AMI.

Patients and Methods: From the obseRvatoire des Infarctus de Côte d'Or (RICO) survey, 614 consecutive patients hospitalized for an AMI from 1st march 2011 to 30 august 2012 and who underwent coronary angiography were included. Patients were analyzed into 3 tertiles of risk based on GS.

Results: The tertiles of risk were defined as low (n = 205)(GS<133), intermediate (n = 204)(GS:133-165), and high risk (n = 205)(GS: >165). Age and co-morbidities increase gradually with increased GS risk. Also, the number of diseased vessels on coronary angiography increased across the tertiles (p<0.001). In-hospital mortality increased from the low to the highest tertile (0.5%, 2.0% and 11.8%, p<0.001). Patients at high risk had significantly higher SS values compared with the intermediate and low GS risk (median (IQR) SS: 13(6-20) vs 9(4-15) vs 7(3-12), respectively, p<0.001). Moreover, SS was strongly correlated with GS (r=+0.254, p<0.001), and remained significant in patients with multivessel disease. By logistic regression analysis, both GS and SS score are significant correlate of hospital mortality (OR(95%CI)1.04(1.02-1.05), p<0.001 and OR(95%CI) 1.11(1.07-1.15)).

Conclusion: Although SS and GS don't share any common items, they are strongly associated for prognostic information. Both scores allow for an accurate personalized assessment of patient risk.

0132

Ischemic mitral regurgitation and non-ST-segment elevation acute myocardial infarction: long-term prognosis in Algerian cohorte

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Introduction and objectives: Ischemic mitral regurgitation (MR) is a common complication of acute myocardial infarction and has a negative impact on prognosis. However, few studies have been carried out on MR after non-ST-segment elevation acute myocardial infarction (NSTEMI). Our objective was to investigate the incidence, clinical predictors, and long-term prognostic implications of MR in patients with NSTEMI.

Methods: The prospective study included 165 consecutive patients who were discharged in functional class I or II after a first NSTEMI. Each underwent echocardiography during the first week of admission, and patients were followed up clinically for a median of 2.3 years. The incidence of readmission for heart failure, unstable angina, reinfarction, death, or all combined (ie, the combined event or major adverse cardiac event [MACE]) was recorded.

Results: The patients' mean age was 68 years and 69% were male. The incidence of MR was 40% (grade I in 45 patients, grade II in 11, grade III in 7, and grade IV in 3). Age, diabetes mellitus, multivessel disease and MR (HR=2.17; 95% confidence interval, 1.30-3.64; P=.003) were all independently associated with a poor long-term prognosis, in terms of MACEs. Even the milder grades of MR were associated with more events.

Conclusions: In our milieu, MR frequently occurs after NSTEMI. Its presence together with other unfavorable factors implies a poor long-term prognosis. This is also true for milder grades of MR. Consequently, MR should be fully assessed and followed-up after NSTEMI in all patients.