score. The Z test for two proportions was used to compare the KSA values with the international figures. Analysis was done using stata 10. Level of significance was set at 5%.

Results: ''Type II: type I DM ratio'' in KSA was comparable to the international ratio (93.65 vs. 93.83). The high risk factors were significantly less prevalent in KSA in comparison to the international Figs. (17% showed significant ST deviation $\geqslant 0.5$ mm vs 46%, ($p = 0.005$), 40% showed positive troponin vs 70% ($p < 0.0001$) and, 32% showed TIMI risk score >3 in comparison to 62% ($p < 0.0001$).

The utilization of GP IIb/IIIa was 18.3% in KSA vs. 37.4% internationally ($p = 0.046$).

On the contrary, the utilization of clopidogril/Ticlopidine was 96.8% in KSA vs. 74.7% internationally ($p < 0.0001$). The percentage of early coronary angiography was 38.9% in KSA vs. 46.1% internationally ($p = 0.292$). Among patients who had early coronary angiography, 34.9% had revascularization (PCI and/or CABG) in KSA in comparison to 54.8% in the international figures ($p = 0.199$).

Conclusions: DM Saudi patients with ACS had similar demographic data to the international patients. There was a satisfactory use of evidence-based medicine in treatment in such group.

Predictors and impact of in-hospital recurrent myocardial infarction in acute coronary syndrome patients: Findings from Gulf RACE

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Introduction: Little in the literature is known about the predictors and the adverse impact of recurrent ischemia and infarction in patients with acute coronary syndrome (ACS). Accordingly; our objectives were to determine the baseline characteristics, risk factors, and long term outcome of patients with recurrent ischemia.

Methods: We evaluated ACS patients who were enrolled in the second Gulf Registry of Acute Coronary Events (Gulf RACE-2).

Results: Out of 7930 ACS patients, 172 (2.2%) developed recurrent myocardial infarction (Re-MI) during their hospitalization. Patients with Re-MI were more likely to be older (mean age 59.12 ± 13.5 vs. 56.8 ± 12.4; $P = 0.016$), had higher rates of hyperlipidemia (41.3% vs. 32.6%; $P = 0.027$) and previous angina (47.7% vs. 37.9%; $P = 0.006$), presented more with STEMI (72.1% vs. 43.9%; $P < 0.001$), and had more Killip class 4 upon admission (8.1% vs. 3.2%; $P < 0.001$) than patients without Re-MI. Management-wise, Re-MI patients received less aspirin (94.8% vs. 98.5%; $P = 0.002$), beta-blockers (59.3% vs. 74.7%; $P < 0.001$), and statin (87.2% vs. 94.9%; $P < 0.001$),

and were less frequently assessed by coronary angiogram (30.8% vs. 32.5%; $P = 0.036$). These patients had more in-hospital complications including congestive heart failure (44.2% vs. 12.4%) and cardiogenic shock (25.6% vs. 5.3%) as well as higher mortality rates; both during hospitalization (23.8% vs. 4.1%) and after a discharge period of 30 days (27.3% vs. 6.8%) and 1 year (29.1% vs. 9.3%). $P < 0.001$ for all comparisons.

Conclusion: Patients with recurrent infarction have a bad prognosis in terms of in-hospital complications and high mortality rates. High risk patients need to be monitored and managed differently to prevent secondary attacks.

Cardiac resynchronization therapy in children with dilated cardiomyopathy: A case series

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Introduction: Dilated cardiomyopathy in children is a serious disease with significant burden and poor outcome. Ventricular desynchrony can lead to dysfunction and dilated cardiomyopathy (DCM). For such patients, cardiac resynchronization therapy (CRT) is a proven form of therapy however; the role of CRT in children is not well studied.

Objective: We aim to describe our experience with CRT in children with poor ventricular function.

Methods: We retrospectively reviewed all pediatric pts who underwent CRT in our institute. Data collected include: demographics, CRT indication, pre and post CRT ventricular assessment using echocardiogram, and follow up clinical evaluation.

Results: Between 09/05 and 12/08, 19 pediatric pts median age 4 years (8months to 16 years) underwent CRT for DCM. The etiology of d DCM was chronic RV pacing with and without congenital heart disease (CHD) in 15 pts, myocarditis in 2, and post repair of CHD 2. The median duration of chronic RV pacing prior to CRT was 4yrs (1-11 yrs) and all developed DCM. One pt had transvenous approach while all other pts had epicardial leads for the left ventricular and atrium. All devices were CRT-P. After 22 months of median follow up (1-46 months), 13 pts improved clinically with or without associated LV remolding. Theremaining 6 pts did not respond to CRT.

Conclusion: CRT is a promising mode of therapy for a subgroup of pediatric patients with poor ventricular function. More studies are needed to identify those who will benefit the most from this mode of therapy.