TIMP-1 and MMP-9/TIMP-3 were still higher in the lesions from unstable (0.24 ± 0.07 and 1.47 ± 0.39) than in those from stable (0.09 ± 0.05 and 0.53 ± 0.19 patients). Immunohistochemistry localized both MMP-9 and TIMPs in macrophages some of which were expressed in the fibrous cap of the ruptured plaque.

Conclusions: Uprogelation of MMP-9 in the plaques from unstable coronary patients was disproportional to that of TIMPs, suggesting that active degradation of extracellular matrix persists in advanced coronary lesions particularly in those from clinically unstable patients.

Ischemia Modified Albumin Improves the Sensitivity and Negative Predictive Value of Standard Cardiac Biomarkers for the Diagnosis of Myocardial Ischemia

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Introduction: We examined the utility of ischemia modified albumin (IMA), both alone and with standard biomarkers of cardiac myonecrosis, for the assessment of patients with suspected myocardial ischemia in the emergency department.

Methods: 200 consecutive patients presenting to the emergency department with symptoms suggestive of myocardial ischemia were evaluated. Measurement of troponin I (TnI), creatine kinase-MB (CK-MB), and myoglobin (Myo) were performed on each patient using a quantitative bedside point of care assay (Biosite, LaJolla, CA) as well as measurement of the IMA with the Albumin Cobalt Binding (ACB) assay (Ischemia Technologies, Denver, CO). Every case (including history, physical, electrocardiogram, stress test and angiography, if applicable) was reviewed, in a blinded fashion, by a cardiologist. A clinical diagnosis of ischemia was assigned based on these data, and then correlated to the results of the biomarker testing.

Results: 13% of the patients were judged to have myocardial ischemia by clinical data. Compared to those patients without ischemia, patients with a clinical diagnosis of ischemia were older (70.5 ± 16.9 vs 65.4 ± 16.9 years, p<0.001), and were more likely to have had a prior diagnosis of coronary artery disease (67% vs 26%, p<0.001) or prior revascularization (28% vs 10%, p<0.002). Furthermore, those patients with ischemia were more likely to have congestive heart failure (20% vs 6%, p<0.002). Utilizing a cutoff point of 90 unit/ml, we found the ACB assay to have 83% sensitivity and 30% specificity for the diagnosis of ischemia, with a negative predictive value of 92%. Among the same group of patients, the triple screen of CK-MB/TnI/Myo had a sensitivity of only 57%. The combination of IMA/CK-MB/TnI/Myo increased the sensitivity for the detection of ischemia to 97%, with a negative predictive value of 92%.

Conclusion: When used in patients with suspected myocardial ischemia, the ACB assay had high sensitivity and negative predictive values. Furthermore, IMA measurement improved the sensitivity of CK-MB/TnI/Myo for the detection of acute coronary ischemia.

Increased Expression of Myeloid Related Protein in Infiltrated Neutrophils in Coronary Atherosclerotic Plaques of Patients With Unstable Angina

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Background: Myeloid related protein (MRP) is expressed in infiltrated neutrophils and macrophages during inflammatory reactions. The purpose of this study was to investigate: (1) whether serum MRP levels are increased in patients with unstable angina (UA), (2) whether MRP levels are upregulated in coronary atherosclerotic plaques of patients with UA. Methods: Serum MRP levels were measured using a sandwich enzyme-linked immunosorbent assay system which was newly developed in our laboratory in 53 patients (64±11 years) with unstable angina (UA), and serum C reactive protein (CRP) levels were measured using a quantitative bedside point of care assay (Biosite, LaJolla, CA) as well as measurement of the IMA with the Albumin Cobalt Binding (ACB) assay (Ischemia Technologies, Denver, CO). Every case (including history, physical, electrocardiogram, stress test and angiography, if applicable) was reviewed, in a blinded fashion, by a cardiologist. A clinical diagnosis of ischemia was assigned based on these data, and then correlated to the results of the biomarker testing.

Results: There were no significant differences between the two groups regarding age, sex, risk factors, and angiographic findings. Serum MRP levels were significantly higher in patients with UA than in those with SA (18.3±14.2% vs. 1.3±2.4%, p<0.0001). Serum CRP levels were also significantly higher in patients with UA than in those with SA (3.1±6.4 mg/dl vs. 0.19±0.2 mg/dl, p<0.005). The percentage of MRP positive area was significantly higher in patients with UA than in those with SA (18.3±14.2% vs. 1.3±2.4%, p<0.0001). In patients with UA, the immunodoublet clearly revealed that MRP was expressed in infiltrated neutrophils and occasional macrophages. Conclusion: The measurement of serum MRP levels and the immunohistochemical approach are useful for the differentiation between UA and SA. MRP may be involved in vulnerability of coronary atherosclerotic plaques in patients with UA.