Introduction: Diagnostic value of circulating D-Dimer (DD) in acute aortic dissection (AAD) has been shown recently. However, there is no data concerning the kinetics of DD in AAD and few is known about prognostic value of DD in AAD.

Objectives: to describe the kinetics of circulating DD during the in-hospital period of AAD in patients and to analyse its prognostic value.

Patients and Methods: consecutive patients presenting with AAD in our institution were included. Follow-up was obtained to determine the total mortality and major events related to AAD i.e. re-intervention, aneurismal evolution, persistence of a circulating false lumen). DD were assessed by immunoturbidimetric method (Stago®, France).

Results: 109 patients (mean age 62 ± 14 years) were included. 76 patients were Stanford A (70%, surgery in 97%), and 33 Stanford B (30%, surgery in 9%). DD levels at admission were 10032 ± 7955 ng/ml. The kinetic of DD followed a “V” curve with a significant decrease until day 2 (nadir) and a slow increase thereafter up to day 8 without difference between the type of dissection or whether the patients were operated or not. Cumulative mortality was 16% in hospital and 28% at a mean of follow up 3.4 ± 3 years. In-hospital mortality was associated with DD level at admission and at day 2 (nadir). Cumulative long-term mortality was only associated with DD level at day 2 (nadir) at the cut-off of 2000ng/ml. DD were not associated with re-intervention, aneurismal evolution or persistence of a circulating false lumen.

Conclusion: DD kinetic in AAD follows a biphasic “V” curve, with a nadir at day 2. In hospital mortality is associated with DD at admission and at day 2. Whereas cumulative long-term mortality is only associated with DD at admission.

The early management of hyperglycemia in patients with AAD is more widespread in CCU than in out of hospital emergency context. Recommendations concerning early hyperglycemia management in patients with ACS have to be more spread among emergency physicians.

343

Does grade 3 ischemia on admission electrocardiogram predicts failure of myocardial reperfusion after coronary angioplasty for acute myocardial infarction?

Khalidoun Ben Hamda, Feriel Mostemiri, Mohamed Amine Majdoub, Khaleda Mzoughi, Sonia Hamdi, Hichem Denguir, Hamza Thawaba, Aziz Boudahjar, Faouzi Maatouk

CHU de Monastir, Service de Cardiologie, Monastir, Tunisia

Failure of myocardial perfusion after coronary angioplasty for acute myocardial infarction (AMI) is associated with a poor prognosis. Grade 3 ischemia (G3I) was shown to be associated with failure of myocardial perfusion.

Aim: Evaluate the prognosis impact of G3I, recorded on the admission electrocardiogram, after percutaneous coronary intervention (PCI) for AMI.

Methods: One hundred eight patients had PCI in the setting of AMI. G3I was defined as: Absence of S wave below the TP-PR isoelectric line in > 2 leads. Patients meeting the ST-elevation criteria but not the G3I criteria were classified as grade 2 ischemia (G2I). Myocardial perfusion was evaluated on ST-segment resolution and angiographically on the flow of infarct-related artery graded according to the TIMI scale. Occurrence of no-reflow, no ST-segment resolution and hospital mortality were evaluated.

Results: Patients were divided in 2 groups: G3I (51 patients) and G2I (57 patients). Clinical and angiographic characteristics were similar, absence of ST-segment resolution, the no-reflow phenomena and hospital mortality were more common in the G3I group respectively: 47% vs 20 % (p=0.002), 27% vs 10% (p=0.024) and 21.6% Vs 8.8% (p=0.062). IG3, female gender, diabetes and delay to consultation > 2 hours were associated with the occurrence of no-reflow, persistence of ST-segment elevation and hospital death. In multivariate analysis, IG3 was an independent factor of no-reflow and absence of ST-segment resolution: OR 3.45 (CI 95% [1.15 to10.31]) p=0.027 and OR 3.47 (CI 95% [1.37 to9.01]) p=0.011, respectively. Female gender, no-reflow and persistence of ST-segment elevation were the only independent predictive factors of hospital mortality, respectively: OR 10.59 (CI 95% [1.68 to66.8]) p=0.012; OR 7.39 (CI 95% [1.52 to35.8]) p=0.013; OR 50 (CI 95% [4,69 to532]) p=0.001 but not the grade 3 ischemia.

Conclusion: Grade 3 ischemia on the admission electrocardiogram of acute myocardial infarction is a strong independent predictors of failure of tissular reperfusion.