Results: Three hundreds and one patients were enrolled. Nine patients (3%) were lost to follow-up at one year. The rates of thrombolic and bleeding events at one year were 7.5 and 6.8% respectively. The mean VASP index after a 60 mg LD of prasugrel was 341±23% and 76 patients (25%) were considered as having high on-treatment platelet reactivity (HTPR). Patients with HTPR had a higher rate of thrombotic events compared to good responders (19.7 vs. 3.1%; p=0.001). Patients with a minor or major non-CABG related TIMI bleeding had lower PR compared to patients with no bleeding events (21.18 vs 35.23%; p=0.008). In multivariate analysis, the VASP index predicted both thrombolic and bleeding events (OR: 1.44 [95% CI: 1.2-1.72]; p=0.001 and 0.75 [95% CI: 0.59-0.96];p=0.024 (respectively, per 10% increase).

Conclusion: Platelet reactivity measurement after prasugrel LD predicts both ischemic and bleedings events at one year follow-up for ACS patients undergoing PCI.

040
Myocardial bridging: comparative analysis of coronary angiography and autopsy results

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Background: Myocardial bridge (MB) is congenital myocardial band overriding a portion of a coronary artery, mainly LAD. Incidence on coronary angiography (CA) appears lesser than on autopsy, which can be ethnics-related, while clinically all forms of coronary artery disease (CAD) are reported: from benign arrhythmias up to sudden death. CA of symptomatic NSTEMI in 26% vs prior wall STEMI angina (7%) and supraventricular arrhythmia (5%), with a history of antecedents dominance (69%). Hypertension and smoking were equally present (69%), and 3-v-CAD (4%). MBs were most frequent in hearts with right coronary artery (75%). 29% were CAD-free, 43% had 1-vessel CAD, 2-v-CAD (24%) and 3-v-CAD (4%). MBs were most frequent in hearts with right coronary dominance (69%). Hypertension and smoking were equally present (69%), dyslipidemia (57%), family history of CAD (48%) and diabetes (21%). Pts presented with stable angina (40%), nonspecific symptoms (14%), unstable angina (7%) and supraventricular arrhythmia (5%), with a history of an anterior wall STEMI vs. NSTEMI in 26% vs. 7%.

Conclusions: This first overview of MBs-incidence in Serbia (0.8% on autopsy vs. 0.9% on CA) might understate its actual presence, which prompted us to continue prospectively.

041
Microalbuminuria and uric acid in acute coronary syndrome

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Background: Microalbuminuria and uric acid are emerging as new coronary risk factors in diabetes and non diabetics, their prevalence as well as their prognostic value in patients with acute coronary syndrome (ACS) are still unclear.

Methods: We propose a prospective study of 175 patients admitted with ACS with ST segment elevation (mean age of 57 ± 9-6 years (28-89 years), 71% were male, 53% are diabetics, 44% are hypertensive, 12% are followed for chronic renal failure and 14.7% are overweight. The SCA affected the anterior territory in 51% of cases. A primary angioplasty was performed in 26% of cases and a thrombolysis in 52% of cases.

Results: Microalbuminuria is positive in 22% of cases, affecting 42% of diabetics and 8.7% of non diabetics, the rate of microalbuminuria is correlated with the blood sugar level in diabetic and non diabetic (r=0.650, p=0.01 and r=0.687, p=0.02).

The uric acid is correlated to the serum creatinine level and the peak of troponin in patients with a creatinine clearance> 60 ml/min (r=0.690, P=0.02 and r=0.740, p=0.001). The uric acid is also correlated to the number of affected coronary arteries (r=0.602, P=0.02). The rate of microalbuminuria is correlated to the distribution of atherosclerosis 13±8 mg in single vessel disease vs. 15±7 mg in two vessel disease Vs 29±5 mg in three vessel disease, p=0.02. In univariate and multivariate analysis, 56% of patients who have microalbuminuria presented a three vessel disease vs 23% among other patients, p=0.01, OR=6.9 (95% ICA 1.7-23) independently of diabetes and hypertension.

Conclusion: The uric acid is not correlated to the diffuseness of atherosclerosis after adjustment to diabetics and kidney failure.

042
Real life dual antiplatelet therapy after NSTE-ACS in a Tunisian population: is there a need for 12 months of treatment?

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Aim: Even if the recommended duration for dual antiplatelet therapy (DAT) after non ST elevation acute coronary syndromes (NSTE-ACS) is 12 months, evidence concerning the benefit of clopidogrel adjunction especially beyond 3 months remains poor. The aim of the study was to assess the effective clopidogrel intake and the incidence of a composite endpoint including all causes death and non fatal myocardial infarction in a Tunisian population after NSTE-ACS.

Methods: We included patients admitted for NSTE-ACS in our department between January 2010 and August 2011 for whom long term evaluation was possible. In-hospital deaths were excluded (including post operative deaths). By telephone follow up, we evaluated the effective DAT duration and the occurrence of all causes death and non-fatal myocardial infarction.

Results: One hundred thirty patients were included. Mean (SD) follow up was 261 (99) days. DAT was effectively observed during 94±103 days (extremes ranging from 0 to 360 days). Angioplasty was performed in 51.5%, coronary artery bypass graft in 8.4% and medical therapy was considered in 40.1%. In 35 (26.9%) patients, aspirin was the only antiplatelet therapy taken after discharge although DAT was prescribed; 46.9% of the patients took the DAT for more than 3 months, and 23.1% for more than 6 months. The composite endpoint occurred in 6 (4.6%) patients: 2 deaths (both of cardiac causes) and 4 myocardial infarctions. Three of them were under DAT, and the 3 others remained event free during 7, 240 and 270 days after clopidogrel withdrawal. These findings suggest that DAT does not protect against death or myocardial infarction. The rebound phenomenon after clopidogrel withdrawal isn’t patent in our population.

Conclusion: In the Tunisian context, DAT observance is poor after NSTE-ACS. Death and non fatal myocardial infarction don’t seem to be reduced by DAT and the rebound phenomenon after clopidogrel withdrawal isn’t patent. This may be in part attributed to the small sample of population and the predominantly low risk (as assessed by TIMI risk score), but larger studies are needed to strengthen the evidence for DAT after NSTE-ACS.