olfine (5ug/kg/min) was infused into LAD through the bypass tube for 20 minutes in either ischemic or nonischemic situations. Results: In the nonischemic heart, rolifonex had no significant hemodynamic and metabolic effects. However, in the ischemic heart, both coronary blood flow (33±2 to 44±3 ml/100g/min, p<0.01) and fractional shortening (79±6 to 11.7±0.7 %, p<0.01) were increased by the rolifonex infusion. Lactate extraction ratio (4.0±0.4 to -18.1±4.8 %, p<0.01) and pH of coronary venous blood (7.27±0.10 to 7.34±0.025, p<0.05) were also increased by rolifonex, indicating the improvement of myocardial anaerobic metabolism. These effects were partially attenuated by pretreatment with either N²-nitro-L-arginine methyl ester (NAME, the inhibitor of NO synthesis) or yohimbine (the inhibitor of phosphodiesterase type 11 (PDE11), and completely abolished by IC182796 (the estrogen receptor antagonist) or L-NAME plus charybdotoxin (the blocker of Ca²⁺-activated K⁺ (KCa) channels). Moreover, increases in both Akt activity and the levels of end products of NO between coronary venous and arterial blood due to rolifonex was completely attenuated by the pretreatment with yohimbine.

Conclusion: These results suggest that both NO and the opening of KCa channels through the activation of estrogen receptors are mainly involved in the mechanism of improving myocardial ischemia, and that NO production is mediated by PI3-K/Akt pathway.

P-PTCA was performed in 721 pts, (median door-to-balloon time 50 min), TT in 1090 pts, and in 418 pts (17.8%). No reperfusion treatment (RT) was given. The incidence of the primary in-hospital combined end points (death, reinfarction and stroke) was similar in pts with TT (8.2%) and P-PTCA (10.7%) (OR 1.19, 95%CI 0.88-1.63), and it was higher (22.6%) (OR 3.30, 95%CI 2.36-4.63, p<0.001) in pts with noRT. The cumulated 12 months combined EP (death, reinfarction, and new admission for angina or congestive heart failure) was also similar after TT (26.2%) and P-PTCA (34.8%) (OR 0.92, 95%CI 0.74-1.14, p=0.45), and it was higher (45.4%) (OR 2.25, 95%CI 1.86-2.98, p<0.001) after noRT. At multivariate analysis (COX), age, anterior AMI, Killip class 1, heart rate and systolic blood pressure on admission were all significantly associated with both primary EPs. The lack of difference in this end points after either treatment was remarkably stable over the 6 years following AMI.

Conclusions: Our results show that either treatment is safe in pts with STEMI, combined end points were similar in pts with TT and P-PTCA, and noRT was less effective than TT in pts with acute MI. Improved management is required for pts currently not receiving reperfusion treatment, whose outcome remains poor.

1122A-165 Six-Year Mortality and Long-Term Risk Model in Older Patients Surviving MI
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Background. Outcomes following myocardial infarction are highly variable and it is often difficult to accurately predict prognosis, particularly in the elderly. Despite the utility of predictive models in clinical practice, few studies have determined the long-term (6 year) prognostic significance of readily available demographic, clinical and functional data in a large national sample of MI survivors.

Methods. We conducted a retrospective cohort study using data from a sample of older patients admitted with AMI in 1992-1993 and a national sample from the Cooperative Cardiovascular Project of patients aged ≥65 years who survived MI from 1994-1999 to determine the distribution of death after MI and to develop a simple risk model that would accurately stratify elderly survivors of myocardial infarction and predict their long-term (6 year) clinical outcomes.

Results. One year and six year mortality in this cohort of 9118 older patients was 17% and 48% respectively. In the derivation set, the factors with the strongest association with mortality at both 6 years were age, female sex, LVEF <40% of normal admission, diabetes, dementia, prior history of AMI or COPD, length of stay greater than 12 days and renal dysfunction (<2.5). Having a revascularization procedure or cardiac catheterization during the hospitalization was associated with a decrease in mortality. Based on the coefficients in the model, a simple risk score was developed. The C statistic for the derivation model was 0.80 and for the validation model is 0.81.

Conclusions. Mortality rates were high in this older cohort, with the majority of deaths occurring in the first 6 months. We demonstrate that a simple risk model was a powerful tool to risk stratify elderly patients over the 6 years following AMI and that predictors of risk were remarkably stable over the six years after MI. Knowledge of long-term risk in this elderly cohort of MI survivors will aid in clinical decision making with regard to further diagnostic testing, interventions and secondary prevention strategies.

1122A-166 Diabetes-Related Knowledge is Not Associated With Measures of Risk Factor Control in Patients With Diabetes and Acute Coronary Syndromes

Background: Diabetic patients have twice the incidence of acute coronary syndromes (ACS) and twice the mortality following ACS compared with non-diabetics. Poor patient understanding of diabetes (DM) is thought to impede appropriate self-management, accelerating cardiovascular complications. We investigated the relationship between patient DM-related knowledge and measures of risk factor control (HbAlc, LDL cholesterol, DBP and body mass index).

Methods: 200 consecutive patients admitted to a university hospital with DM and ACS (ST-segment elevation and non-ST-segment elevation MI or unstable angina) were enrolled. At enrollment, clinical and demographic data were recorded. Each patient completed a previously validated DM-related knowledge assessment (DRKA). Preliminary results for the first 151 patients are included. Complete results, including 6-month clinical outcomes (death, MI, and revascularization), will be presented.

Results: Median age was 61 years; 38% of patients were female; 62% Caucasian, 27% African-American, and 11% Lumbee Indian. Mean education level completed was 11th grade. Hypertension (86%) and hyperlipidemia (65%) were common; 22% of patients were current smokers. Duration of DM was >10 years in 50% of patients, and 40% were taking insulin. Mean values ± SD were HbAlc 7.9% ± 1.7%, LDLc 105mg/dL ± 36mg/dL; BMI 31±5 kg/m². Mean values ± SD were 42±7 years of DM, 22±20 years of education and DM-related knowledge. However, we found no correlation with age, race, insulin requirement, duration of DM and years of education.

DRKA scores were moderately correlated with HbAlc (r=0.22; r=-0.01; r=0.12, respectively). The lack of correlation between DRKA and measures of risk factor control (HbAlc, LDL cholesterol, SBP, DBP and BMI) was statistically significant at p<0.05 level.

Conclusions. Knowledge of DM is not associated with measures of risk factor control in patients with diabetes and acute coronary syndromes.

1122A-167 Higher Procedure Use in the United States Versus Canada Among Non-ST-Elevation Acute Coronary Syndrome Patients Not Associated With Better Quality of Life Outcomes
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Comparison of United States (US) and Canadian (CN) practice patterns and outcomes offers a natural experiment to examine the relative benefits of aggressive versus conservative management of non-ST-elevation (NSTEMI) acute coronary syndrome (ACS) patients (pts) and their differential impact on qualify of life (QOL). In a prospectively designed sub-study of GUSTO-Ib, we examined QOL at baseline and at one-year among a random sample of 1222 US and 463 CN pts. There was no change in pts' functional status during the 1-year follow-up in either country (Table). By 1-year, CN CAEBG rates were at par with those in the US. However, CN cardiac catheterization and PCI rates continued to be significantly lower.

In conclusion: contrary to prior findings in the ST-elev MI population, significantly higher management in the US did not translate into improved QOL status in this non-ST-elev ACS cohort. Our QOL results are aligned with those of earlier clinical trials, this is not true of most registries, and prospective studies in high-risk populations showing no association between aggressive intervention and improved clinical end-points in this pt population.

1122A-168 High-Risk Myocardial Infarction: In-Hospital and One-Year Outcome After Primary Angioplasty and Thrombolysis: A South African Prospective Multicenter Study
Giuseppe Staffanino, Diego Ardissoni, Samuele Baldasseroni, Francesco Ciravera, Donata Lucci, Patrizia Maras, Maurizio Marini, Francesco Mauri, Giovanna Maria Santoro, Roberto Volinia, Alberto P. Maggioni, on behalf of MISTRAL Investigators, ANMCO Research Center, Florence, Italy

Background. Although primary angioplasty (P-PTCA) is superior to thrombolysis (TT) in randomised trials, this is not true of most registries, and prospective studies in high-risk (HR) pts are scarce. We observed the applicability and the acute and long-term outcomes of other treatment in HR pts with AMI in the community setting.

Methods and Results. At 17 sites with, and 30 without, P-PTCA facilities, 2221 pts with ST elevation AMI 770 y (17.9%), diabetic >70 y (9%), Killip class >1 (23.7%), SBP 100 b/m (2.7%); >4 leads with ST deviation (81.9%), previous MI (11.4%), contra-indication to TT (10.2%).

Wednesday, March 20, 2002, 2:00 p.m.-3:30 p.m.
Georgia World Congress Center, Ball G Presentation Time: 2:00 p.m.-3:00 p.m.

POSTER SESSION
1122A Assessment and Outcomes of Acute Coronary Syndromes
Monday, March 18, 2002, Noon-2:00 p.m.
Georgia World Congress Center, Hall G Presentation Time: 1:00 p.m.-2:00 p.m.