developed HBV seroconversion. Overall, survival in this small cohort was not different than that for all patients transplanted at our center during this time period. Conclusion: Transplantation of hearts from HBsAg+ donors is associated with a low HBV transmission rate and the transplantation of hearts from donors with intracranial tumors is not associated with tumor transmission. Use of hearts from these marginal donors should be considered safe and may help to augment the available donor pool.

1137-63 Recent Outcomes in Cardiac Transplant Patients Receiving Hepatitis C Allografts: A Single Center Experience
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Background: Hepatitis C infection in the non-immunocompromised population is a chronic progressive disease with clinical manifestations after several years. The long- term impact of Hepatitis C following heart transplantation remains unclear.

Methods: Medical records pertaining to heart transplant recipients receiving allografts from hepatitis C positive donors between August 1991 and August 2002 were reviewed retrospectively. 33 patients were identified as having received allografts from hepatitis C positive donors. Of these, 7 recipients were hepatitis C positive prior to transplantation and 9 patients were Status 1 listing. Overall survival was determined. The presence of diabetes mellitus, hypertension, renal function, post-transplant albumin, donor age, pre- transplant hepatitis C status and type of immunosuppression used were determined to assess possible predictors of outcome.

Results: Of patients receiving hepatitis C positive allografts was 57% at one year and 17% at 5 years. This compared to an overall one-year survival of 62% at one year and 70% at 5 years for all adult heart transplants. Causes of death were due to high intracranial pressure and/or sepsis (2), liver failure (2), transplant coronary artery disease (2), unexplained sudden death (2), malignancy (2), rejection (1), and pulmonary embolus (1). By multivariate analysis and logistic regression, the only significant predictor for mortality was the recipient's hepatitis C status (p<0.001).

Conclusion: Patients receiving hepatitis C positive cardiac allografts have a significantly worse outcome when compared to the outcome for all adult heart transplants in our institution. The use of cardiac allografts from hepatitis C positive donors should be restricted to patients with high risk conditions. Further investigation is currently underway to study this.

1137-64 The Vagary of B-Type Natriuretic Peptide Levels in Heart Transplant Recipients Receiving Tacrolimus
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Background: Tacrolimus (FK506) is a potent immunosuppressant often used in place of cyclosporine (CSA) in heart transplant (HT) patients. Prior studies in HT patients on CSA or FK506 have demonstrated that B-type natriuretic peptide (BNP) levels are elevated and to be implied in GVD pathogenesis, their contribution to remodeling process remains undefined.

Methods: Medical records pertaining to heart transplant recipients receiving allografts from hepatitis C positive donors between August 1991 and August 2002 were reviewed retrospectively. 33 patients were identified as having received allografts from hepatitis C positive donors. Of these, 7 recipients were hepatitis C positive prior to transplantation and 9 patients were Status 1 listing. Overall survival was determined. The presence of diabetes mellitus, hypertension, renal function, post-transplant albumin, donor age, pre- transplant hepatitis C status and type of immunosuppression used were determined to assess possible predictors of outcome.

Results: Of patients receiving hepatitis C positive allografts was 57% at one year and 17% at 5 years. This compared to an overall one-year survival of 62% at one year and 70% at 5 years for all adult heart transplants. Causes of death were due to high intracranial pressure and/or sepsis (2), liver failure (2), transplant coronary artery disease (2), unexplained sudden death (2), malignancy (2), rejection (1), and pulmonary embolus (1). By multivariate analysis and logistic regression, the only significant predictor for mortality was the recipient's hepatitis C status (p<0.001).

Conclusion: Patients receiving hepatitis C positive cardiac allografts have a significantly worse outcome when compared to the outcome for all adult heart transplants in our institution. The use of cardiac allografts from hepatitis C positive donors should be restricted to patients with high risk conditions. Further investigation is currently underway to study this.

1137-66 Survival Pre and Post-Heart Transplantation in Patients Listed as UNOS Status 2: Do UNOS Status 2 Patients Benefit From Transplantation?
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Introduction: Improved outcomes with contemporary medical therapy in patients with advanced heart failure questions the cost-effectiveness of transplantation (TX). However, the survival benefit at one year in transplantsing UNOS status 2 patients has not been determined.

Methods: Between January 1999 and June 2001, 4,255 patients were listed for heart TX as UNOS status 2. Using a competing risk model, probabilities of events on the waiting list were computed. Additionally, a time dependent proportional hazards model was used to determine predictors of death pre and post TX.

Results: Demographic of this cohort revealed: mean age of 56.0 years, female gender (23%), ischemic etiology (48%), diabetes (21%), white race (85%), and mean time on the waiting list (398.5 days). Relative risks of death (> 1 indicates an increased risk) compared to patients waiting on the waiting list as status 3 were: upgrade to status 2; RR 0.7 (95%CI 0.6-0.8) upgrade to status 1A; RR 1.4 (95%CI 1.2-1.6). Overall relative risk of death following TX (365+ days) for status 2 patients initially listed as status 2 compared to those that continued to wait as status 2 was shown below RR 0.92 (95%CI 0.5-1.58, n=87). Conclusion: After accounting for early perioperative mortality, there appears to be little survival benefit at one year in transplantsing UNOS status 2 patients. The point of optimal benefit from TX in UNOS status 2 patients may need to be further defined.

1137-67 Cytomegalovirus Infection Negatively Influences Coronal Remodeling Morbidities in Heart Transplant Recipients: A Prospective Study
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Background: Cytomegalovirus (CMV) infection is a major determinant of mortality after heart transplantation (HT). The peculiar form of atherosclerosis has been recently identified as the result of the interaction between intimal hyperplasia and vessel wall response (i.e. vascular remodeling). Although immunological and traditional risk factors are known to be implicated in GVD pathogenesis, their contribution to remodeling process remains undetermined.

Methods: 27 consecutive HT recipients were prospectively studied (age 52±11yrs; 75% male; median age 50±11yrs). Intracoronary ultrasound (IVUS) of proximal-mid left anterior descending was performed at 1 and 12 months after HT. Vessel, lumen and intimal volume changes over this period were analyzed.

Results: Overall intimal volume increased (+80%, P<0.01) while vessel volume remained unchanged (+0.5%, P=0.1) and thus, lumen volume decreased (−9%, P=0.01). Among all the clinical and demographic characteristics analyzed (e.g. donor features, immunosuppression, lipid panel, biopsy score), only the presence of CMV infection was associated with increased lumen loss (P=0.047). Patients who presented CMV infection (n=14) showed a higher increase in intimal volume (118% vs. 59%, P=0.07), but not in vessel volume (+11% vs. +4%, P=0.5). Therefore, CMV infected patients showed a more significant lumen loss (13% vs. 5%, P=0.04). A trend towards an association between LDL and intimal growth was present only in CMV infected recipients (R=0.46, P=0.07).

Conclusions: The prospective study suggests for the first time that occurrence of CMV infection during the first post-HT year negatively affects vessel wall response (i.e. vascular remodeling). Further investigation is required in order to confirm our results, in order to prevent CMV infection and to stimulate vascular growth.