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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 day2 (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 day2, whereas cumulative long-term mortality is only associated with DD levels at day 2. These results suggest that a DD dosage at admission and at day 2 in AAD might be of help for the patient prognosis evaluation.

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French national survey on the hyperglycemia management in acute coronary syndrome, comparison between coronary care units and out-of-hospital mobile emergency units practices

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Background: The 2006 French recommendations concerning acute myocardial infarction management occurring out of cardiologic unit recommend a close control of glycemia. The aim of our study was to assess spread of these recommendations.

Methods: We conducted in 2008 a national phone survey in coronary care units (CCU) and out-of-hospital mobile emergency units (SMUR). Senior physicians were asked about local hyperglycemia protocol management for patients with acute coronary syndrome (ACS).

Results: The mains answers from the cardiologists and the emergency physicians (EP) are listed in the table.

	CCU n=125	SMUR n=245
Systematic glycemia dosage in patients with chest pain	55 %	55 %
Systematic glycemia dosage in patients with ACS	59 %	63 %
Specific insulin protocol in patients with ACS	55	14
Same hyperglycemia treatment for diabetic and non diabetic patient	52 %	62 %
% of physicians who have already treated hyperglycemia during ACS	98 %	37 %

Only 50 percent of the SMUR have insulin for out of hospital treatment. In the CCU the first result of glycemia is a capillary dosage for 64% and a blood dosage for 36%.

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The glycemia threshold for the insulin treatment ranges from 1 to 3 g/l. For 14% of EP there is no indication of hyperglycemia treatment during the out of hospital management of ACS. For 99% of cardiologists there is an indication of treatment by insulin for hyperglycemia during the ACS.

Conclusion: The early management of hyperglycemia in patients with ACS 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.

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

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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 angiographyally 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.