were at increased risk of go-day mortality (Figure). In a Cox multivariate analysis, HNa of Dts. Na decreased to 126.130 mmol/L in 29 ots and to <125 mmol/L in 7 ots. Although receiving diuretics, Kaplan-Meier survival curves indicated that pts who developed HNa remained a significant and independent predictor of go-day mortality (RR 3.0, 95% CI 1.3-6.5, p = 0.006).

Conclusion: CRP level on admission is a powerful predictor of 30-day mortality in patients with acute myocardial infarction (AMI), and its relation to measures of infant size.

Methods: CRP was measured within 24-h of symptoms onset in a prospective series of 348 consecutive patients (mean age 62 ± 13 y, men - 76%) with AMI (290 with ST-elevation AMI). Echocardiographic examination was performed on day 2 or 3. Thirty-day mortality was evaluated using Cox proportional-hazards model with the following covariates: age, gender, prior aspirin use, Killip class, diabetes, peak CK, SBP < 100 mm Hg, echocardiographic wall motion score index (WMSI), and reperfusion therapy (primary angioplasty and/or intra-aortic balloon pump therapy).

Results: Patients with CRP levels in the upper tertile (>2.2 mg/UL) had higher peak CK (845 ± 509 vs 544 ± 354, p < 0.0001) and higher echocardiographic wall motion score index (1.7 ± 0.4 vs 1.5 ± 0.4, p < 0.0001). Kaplan-Meier survival curves indicated that pts with CRP levels in the upper tertile were at increased risk of 30-day mortality (Figure). In a Cox's multivariate analysis, CRP level in the upper tertile was a significant and independent predictor of 30-day mortality (Relative Risk = 3.2, 95% CI 1.2-8.2, p = 0.007).

Conclusion: CRP level on admission is a powerful predictor of 30-day mortality in patients with AMI independent of infant size and other traditional predictors of outcome.