presence of CAD based on angio or documented MI.. There were 11250 patients, we divided the cohort in to 2 Groups, namely, CAD + (Group 1) and CAD − (Group 2).

Results: Group-wise comparison showed the following Results: Mean age in Group I significantly higher. (56.36 Vs 52.95) p ≈ 0.0000. There were significantly higher number of males in Group 1. (6125 Vs 2682) p ≈ 0.0000. DM (41.5%Vs 21.8%) p ≈ 0.0000. Smoking (13.1%Vs 5.7%) p ≈0.0000 were significantly higher in Group 1. Mean HDL was significantly lower in Group 1. (39.42 Vs 41.75), p ≈ 0.0000.

Stepwise logistic regression was done on 10,615 patients which showed the following.

From the logistic regression analysis, adjusted for TC, TC/HDL, HDL/LDL, HDL and HTN it is observed that:

CAD risk 3.037 times higher in males and 2.535 times higher in DM, 2.107 times higher in smokers, 1.029 times higher with each unit increase in Age. Not adjusting for Gender, analysis showed CAD risk is 2.458 times higher in DM and 2.751 times higher in smokers. Using Logistic regression model we found that in a 55 year old male, presence of diabetes increases the risk further by 18.82% and presence of smoking further increases by 9.15%.

Conclusion: 1) Traditional risk factors as age, DM, smoking have significant association with CAD. 02) Average lipoprotein levels were lower in our population.

High dose statin study

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Background: There has been no Indian data on high dose statin in our country.

Aims: To assess the tolerability and safety (A 80) in high risk patients.

Methods: This is a retrospective observational study. 272 consecutive patients who were prescribed A80 and could be followed for 2 years formed the cohort. Data were retrieved from inpatient and outpatient records. Baseline demographics, initial diagnosis, interventional procedure done, list of concomitant medications, side effect profile, reason for dose reduction were all obtained and analysed.

Results: There were 238 males (87.5%) & 34 females (12.5%) Mean age was 56.4 year. HT was seen in 119 (43.75 %). DM in 109 (40.07%) Dyslipidemia in 114 (41.9 %) Tobacco use in 75 (27.57%) 236 (86.7%) patients presented with acute coronary syndrome. 204 (75 %) STEMI; 17 (6.25%) NSTEMI and 14 with unstable angina: (5.14%) 116 patients had 2VD on CAG. Mean TC 186, HDL 36.01, LDL 119, TG 143; Mean reduction in LDL was 49.3% in six months. 83 (30.51%) patients had their dose reduction for various reasons. Maximal reduction was seen in first six months, [(49/83). 62%]. 35 patients had dose reduction due to financial reasons (43%). 29 patients had dose reduction without any reason in the case file (34%). 15 patients had dose reduction due to side effects (18.07%). Cough was seen in 4 (1.47%), Abdominal pain 2 (0.735%), Constipation in 3 (1.10%), Headache in 3 (1.10%) and Tiredness in 1, necessitating dose reduction. One each had SGPT and CK elevation requiring dose reduction. CK elevation more than 10 times was seen in one patient requiring stopping the statin.

Conclusion: High dose statin therapy (A80) is safe, tolerable with minimal side effects and should be prescribed to all deserving patients similar to our study group.

Our experience of CTO angioplasties

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Background: Chronic total occlusion is defined as complete occlusion of the coronary vessel with TIMI O flow, present for an estimated duration of >3 months. Studies have found a frequency of 15-20% of CTO in angiographies. Chronic total occlusion PCI has experienced significant growth in the last few years with the adaptation and refinement of advanced techniques.

Methods: Over the past 3 years, more than 250 CTO PTCA were performed at ourcentre. We present an analysis of these CTO PTCA done at our centre. Subjects were analysed with respect to demographics, presentation, outcome and material used.

Results: Of the patients, males composed 72 % and females 28 % of patients. The predominant presentation was chronic stable angina (42%) followed by unstable angina (24%) and NSTEMI. The average LV function was 45%, while viability of myocardium was confirmed with stress thallium scans. The vessels involved were LAD: 38%, RCA: 42%, and LCX: 20%. In 82% procedures, TIMI III flow could be established without any complications. 12% procedures were unsuccessful, primarily due to inability to cross the lesion. Complications occured in 15 % of CTO PTCA. Of these, the commonest was: flap formation (7%). Perforation occured in 6% of patients, of which 2 required placement of a covered stent, while the others were managed by balloon occlusion. 2% patients required pericardial tapping. Contrast induced nephropathy occured in 1 patient, while 4 patients succumbed in the periprocedural period. 64% of the lesions were negotiated using regular angioplasty wires (our workhorse FIELDER FC PTCA wires), while 36% required use of CTO wires.

Conclusion: CTO PTCA is one of the final frontiers of coronary interventions, our experience shows that CTO PTCA shows promising results, with complications rates that are progressively diminishing. We would like to highlight that a majority CTO PTCA were carried out using regular angioplasty wires with balloon support as opposed to CTO wires.

Role of erythrocytes in coronary artery disease

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Background: Association of Red blood cell distribution width (RDW) and coronary artery disease (CAD) is well established. But other erythrocyte parameters Mean corpuscular volume (MCV), Mean corpuscular Haemoglobin (MCH), Mean corpuscular haemoglobin concentration (MCHC) importance in pathogenesis of CAD is not studied.

Methods: Retrospective analysis of 765 patients' records (with complete Haemogram), who underwent coronary angiogram for suspected CAD in yearr 2013 at a tertiary care hospital were included in this study. Patients were grouped into angiography positive (AGP) (N=438), angiography negative (AGN) (N=327) based