		.001	.0002				
# days of poor physical health	4 8	.4352					
			.002				
# days of poor mental health	4 8	.3870					
			.007				
# days of functional impairment	4 8	.3982	.3811				
			.005	.008			

N =# of states whose data was used in analysis; corco=correlation coeffecient.

Conclusion: In a national sample of community dwelling elderly, self-reported health-related variables were significantly associated with hospital admission rates for CVD. These variables included factors related to life style, prevention, access, and health status. While our findings should be viewed as hypothesis generating, they provide insight into risk factors for CVD in the elderly, and support the promotion of healthy lifestyle behaviors and the improvement of access to care as potentially effective mechanisms for the prevention and control of cardiovascular disease in this population.

1128-129 **The Incidence and Prognostic Value of Exertional Hypotension in Medically Managed Older Patients With Stable Coronary Artery Disease**

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Background: The elderly are the fastest growing segment of patients with coronary artery disease (CAD). Since optimal management of CAD requires several drugs that lower blood pressure, we studied the incidence and prognostic value of exertional hypotension (EH) in older patients with stable CAD.

Methods: 564 patients (mean age 67) were studied prospectively. EH was defined as a drop in blood pressure below the resting value. Occurrence of death and/or non-fatal myocardial infarction (MI) was the primary endpoint.

Results: 90 patients (16%), mean age 69, experienced EH. Older age (HR 1.3, 95% CI 1.02 -1.65, p = 0.03), and the use of multiple vasoactive drugs (HR 1.4, 95% CI 1.1 - 1.8, p =0.006) were predictive of EH. In univariate but not in multivariate analysis, EH was associated with a higher risk for the primary endpoint (HR 1.67, 95% CI 1.01- 2.77, p < 0.05). Beta-blocker use (HR 0.47, 95% CI 0.26 – 0.85, p = 0.01), and longer treadmill time (HR 0.40, 95% CI 0.25 – 0.64, p < 0.001) were associated with improved outcomes. EH occurring with ischemia was strongly associated with the primary endpoint (4.8% versus 1.6%, p=0.04, % annually). EH without ischemia posed no additional risk (1.6% versus 1.2%, p = 0.41, % annually). Finally, EH developing after stage 2 of the Bruce protocol was not associated with worse outcomes.

Conclusions: EH is common in older patients with stable CAD managed with multiple medications and is not strongly predictive of worse outcomes in the absence of ischemia and/or impaired exercise tolerance.

Predictors of MI and/or Death

Predictors of EH	Hazard Ratio	95% C.I.	p value
Age	1.30	1.02 - 1.65	0.03*
# of Drugs	1.39	1.10 - 1.75	0.006*
Predictors of Non-fatal MI or Death	Hazard Ratio	95% C.I.	p value
EH	1.52	0.88 - 2.66	0.14
Beta-blocker use	0.47	0.26 - 0.85	0.01*
Treadmill Time (> 6 min)	0.40	0.25 - 0.64	< 0.001*
History of hypertension	1.33	0.80 - 2.21	0.27
Left Ventricular Function	0.88	0.73 - 1.07	0.20
# of Drugs	1.42	1.05 - 1.92	0.03*
Ventricular Arrhythmia during Exercise testing	0.85	0.12 -6.31	0.88

1128-130 **The Blood Pressure Response to the Valsalva Maneuver: An Independent Predictor of Mortality in Elderly Cardiac Patients**

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Introduction: The number of elderly cardiac patients is increasing. The prognosis of these patients is poor. Yet, it is difficult to estimate the prognosis for an individual patient. The blood pressure (BP) response to the Valsalva maneuver (VM) is related to cardiac filling pressure and may be used to estimate prognosis. We studied if the BP response to the VM was associated with mortality in elderly patients with various cardiac disorders.

Methods: In 93 patients, aged 71±5 yr (mean±SD) undergoing right-sided catheterization, the VM was performed. Continuous BP was measured non-invasively with Finapres. From the BP response to the VM, the Pulse Pressure Ratio (PPR) was calculated as the ratio of lowest and highest PP. Survival was assessed from medical files or by telephone.

Kaplan Meier survival was calculated for PPR tertiles and Cox regression for the prognostic value of PPR together with established prognostic variables.

Results: Follow-up period was 28 months. Survival differed significantly over the tertiles (Figure). PPR was an independent predictor of death; Hazard Ratio: 1.56 (per step of 0.1); 95%CI: 1.14 - 2.12, P=0.006), in a model with age, gender, LVEF, HF admittance, myocardial infarction, heart rate, presence of pulmonary rales, NYHA class.

Conclusion: In this group of elderly cardiac patients, the PPR of the Valsalva maneuver was an independent non-invasive prognostic marker for mortality. Prospective studies on the predictive value of the BP response to the Valsalva maneuver are warranted.
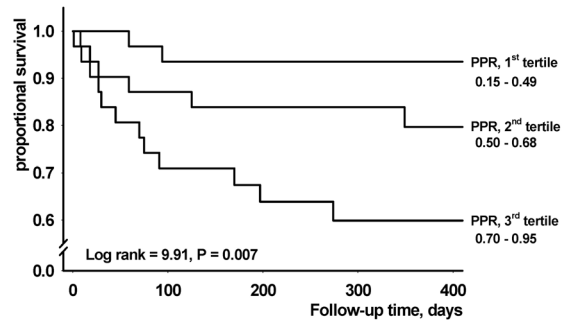
1128-131 **Do Elderly Patients With Acute Myocardial Infarction Show the "Smoker´s Paradox"? Results From the PPRIMM75 Registry**

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Background. Although smokers (S) are at an increased risk of myocardial infarction (MI), the outcome of MI is better in S than in non-S. The reason for this paradox is uncertain but it has been attributed, at least in part, to the younger age of S.

Methods. To assess if the smoker's paradox is present in a population of advanced age, we studied baseline characteristics and outcomes in 677 consecutive patients enrolled in the PPRIMM75 Registry from 1988 to 1997 (aged >75 years and admitted to our CCU with a first AMI).

Results: S were younger (79 vs 80.7 years)*, and less frequently female (5.4 vs 63%)*, diabetic (26 vs 34%, p=.06) and hypertensive (32 vs 57%)*, but had more often peripheral artery disease (24 vs 11%)*. S arrived earlier (delay <6h: 30 vs 38%, p=.08) and were more frequently in Killip class I (77 vs 63%)*. They presented similar rates of ST-segment elevation (84%) and of anterior MIs (34%). No differences between S and non-S were found in the use of reperfusion therapy, echocardiography and coronary angiography. Stress tests were more frequently used in S (34 vs 13%)*. LVEF was similar in both groups. During hospitalization, S showed a lower incidence of pulmonary congestion (32 vs 44%, p<.02), cardiogenic shock (14 vs 19%, p=.13), mechanical complications (6 vs 10%, p=.16). In-hospital mortality rate was 22% in S and 33% in non-S (p=.012). After adjusting the difference in age by logistic regression analysis smoking remained as an independent predictor of death (OR: 0.62; 95%CI: 0.39-0.99). However, when the other baseline differences and Killip class were taken into account, smoking lost its "protective" effect (OR: 0.85; 95% CI: 0.49-1.47). After a mean follow-up of 51 months, S showed a slight advantage in survival (p=.091). When baseline characteristics and Killip class were included in a Cox regression model, S did not show any difference in long-term outcome (OR: 1.08, 95%CI: 0.82 - 1.42). * p<0.01

Conclusion. The smoker's paradox can also be observed in elderly patients with AMI. However, most of the short-term mortality advantage is offset when baseline characteristics are controlled. There is no long-term survival benefit associated with smoking in older patients.

1128-132 **Influence of Age on Atrial Fibrillation Induction**

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Background : atrial fibrillation (AF) induction is used as a diagnostic test of atrial vulnerability in adults; some electrophysiologic changes were reported during the life; AF prevalence is known to increase in elderly people; however, the effects of age on AF induction are unknown. The purpose of the study was to evaluate the effects of age on atrial fibrillation induction. Methods : population of study consisted of 757 patients without spontaneous AF, aged from 16 to 85 years (y) (mean 61±15), admitted for an electrophysiologic study, indicated for dizziness or ventricular tachyarrhythmia. Programmed atrial stimulation was systematically performed : 1 and 2 extrastimuli were delivered in sinus rhythm and 2 atrial driven rhythms (600, 400 ms). AF induction was defined as the induction of AF lasting more than 1 minute. Clinical and electrophysiological data were statistically analysed.

Results : AF induction was paradoxically decreased in the elderly patients (>70 y) compared to patients younger than 70 y (p <0.01) : AF was induced in 40 % of 64 patients younger than 40 y, 39 % of 103 patients aged 40 to 50 y, 37 % of 131 patients aged 50 to 60 y, 38 % of 224 patients aged 60 to 70 y and only 28 % of 235 patients older than 70 y. There was no significant correlation with the sex, the presence of dizziness, the presence of an underlying heart disease, the left ventricular ejection fraction, the presence of salvos of atrial premature beats on Holter monitoring and the intra-atrial conduction time. There was a significant correlation with a longer effective atrial refractory period in the