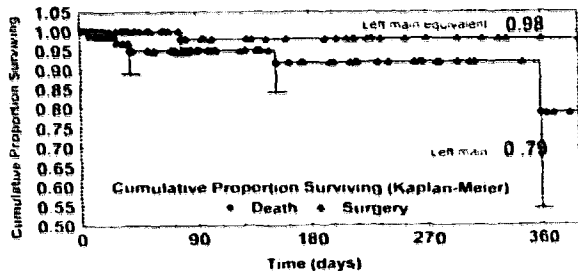


for isolated CABG between July 1 1993 and Dec 31 1995. Patients were censored from follow-up at the time of CABG.

**Results:** 101 patients had  $\geq 50\%$  LM stenosis (by QCA) and 103 had LMEQ disease. Median age was 66 (57-69, IQ range) and 64 (57-69) years, 25 and 34 were women, 43 and 40 had Class IV angina, and median waits for CABG were 64 (12-215) and 95 (21-365) days in the LM and LMEQ groups. Freedom from death at 1 year was 0.79 in all LM and 0.94 in LM patients with Class I-III angina at referral, and 0.98 and 0.98 in each LMEQ group. There were frequent readmissions, usually with unstable angina; freedom from death, MI or readmission was 0.46 and 0.53 in the LM and LMEQ groups.



**Conclusions:** Survival in patients with LM or LMEQ disease may be better in the 1990's than in the 1970's but readmission is frequent, resource utilisation is high, and potentially preventable deaths occur.

5:15

**859-6 Patient-Physician-Medical Record Disagreement on Cardiovascular Risk Factor Management**

S. Mora, R.S. Stafford, R.E. Chaput, T. Bishop, R.C. Pasternak. Massachusetts General Hospital, Boston, MA, USA

Effective risk factor (RF) management depends on reliable communication between physicians and patients (pts). We investigated levels of concordance between pts, physicians, and the medical record for selected RF activities.

**Methods:** A cross-sectional survey of 234 pts in a cardiology practice composed of 28 cardiologists was undertaken. Phone interviews with pts were conducted 3-7 days after the visit. Information from pts and physicians was compared with documentation in the medical record for blood pressure (BP) values, cholesterol testing, diet assessment and diet counseling.

**Results:** BP measurements were reported by 99% of physicians, 97% of pts, and 94% of medical records. Cholesterol testing was reported by 19% of physicians, 13% of pts, and 15% of medical records. Diet assessments were reported by 74% of physicians, 51% of pts, and 43% of medical records. Diet counseling was reported by 50% of physicians, 39% of pts, and 24% of medical records. Pts' recall of systolic and diastolic BP measurements correlated strongly with actual values (correlation coefficients 0.96 and 0.91,  $p < 0.001$ ; mean systolic BP difference 1.8, SD 4.6).

**Conclusion:** Pt-physician-medical record agreement on RF interventions during visits was strong for BP and cholesterol. Compared with patient and medical record documentation, physicians over-reported diet interventions, suggesting that different baseline RFs influence communication and documentation of RF interventions.

**860 Ischemic Complications of Coronary Interventions**

Tuesday, March 31, 1998, 4:00 p.m.-5:30 p.m. Georgia World Congress Center, Lecture Hall 1

4:00

**860-1 Lack of Association of Intermediate CPK-MB Elevation and Late Mortality in Patients Treated With Intracoronary Stents**

J.F. Saucedo, J.J. Popma, R. Mehran, T. Bucher, A.S. Abizaid, M. Curran, M. Mastoor, K.M. Kent, A. Pichard, L. Sattler, M.B. Leon. Washington Hospital Center, Washington, D.C., USA

We have previously reported an association between intermediate level CK-MB elevation and late mortality after atheroablative new device angioplasty. To determine whether this association is also present in pts undergoing stent placement, we reviewed the late clinical outcome of 900 consecutive pts (1213 lesions) undergoing successful stenting in native vessels. Postprocedural CK-MB were normal (N) in 65%, 1-5 x N in 26% and  $> 5 \times N$  in 8%

of pts. Although late mortality was higher in those pts with CK-MB  $> 5 \times N$ , no association was found between intermediate level CK-MB elevation and late mortality. (Table).

	Normal N = 585	1-5 x N n = 238	> 5 x N n = 77
Death, %	1.7	1.2	6.9**
MI, %	1.0	0.8	4.1**
CABG, %	6.2	9.8	8.3
PTCA, %	19.0	14.1	23.6
Death/MI/CABG/PTCA, %	24.9	24.3	37.5*
TLR (CABG/PTCA), %	16.1	15.1	18.1

\*  $p < 0.05$ , \*\*  $p < 0.01$  comparing with normal CK-MB group

Multivariate analysis also showed and increase risk for MACE in the highest CK-MB group (RR: 1.70,  $p < 0.05$ ) but not in the intermediate CK-MB group ( $p = 0.2$ ).

**We Conclude:** 1) Intermediate CK-MB elevations are frequent after coronary stenting (26%), and 2) are not associated with late mortality or clinical events.

4:15

**860-2 Creatine Kinase-MB Enzyme Elevation After Coronary Intervention With Different Devices**

S.K. Sharma, A. Kini, S. Kini, R. Vidhun, G. Dangas, S. Duvvuri, T.P. Cocke, J.D. Marmur, J.A. Ambrose. Mount Sinai Hospital, NY, USA

Creatine Kinase-MB (CK-MB) elevation has been shown to occur after successful intervention and is a predictor of late cardiac events, MI and death. Preliminary reports have revealed higher CK-MB elevation after newer devices (D) such as rotational atherectomy (RA), stent, directional atherectomy (DCA), transluminal extractional catheter (TEC), compared to balloon angioplasty (PTCA). We report the incidence of CK-MB enzyme elevation within 24 hrs of intervention in 842 consecutive patients in relation to different types of intervention. Patients with acute MI (38), Urokinase infusion (8) or elevated preprocedural CK-MB (10), were excluded. Procedural success ( $< 50\%$  diam. obstruction post procedure) was 98.2%, and major complications of acute closure, subacute stent thrombosis, Q-wave MI, emergent CABG, or in-hospital death occurred in 6 patients (0.7%).

**Results:** Overall incidence of any CK-MB elevation was 15.7%, and was not different after single vessel versus multiple vessel intervention. CK-MB in various devices:

CK-MB	PTCA n = 105	RA n = 238	Stent n = 232	DCA n = 25	TEC n = 20	Combined D n = 222
Any rise	6.7%	14.3%	16.8%	20%	20%	19.4%
1-3X	4.8%	10.9%	10.8%	20%	10%	15.3%
3-5X	0	1.3%	3.4%	0	5%	3.6%
> 5X	1.9%	2.1%	2.6%	0	5%	0.5%

\*  $p < 0.005$  vs PTCA. There was a trend toward lower CK-MB elevation after RA alone vs stent alone ( $p = 0.07$ ) despite the similar ReoPro use (70% in RA, 29% in stent) ( $P = NS$ )

**Conclusions:** CK-MB elevation is more frequent after new device interventions compared to PTCA. Contrary to prior data, RA was not associated with a higher incidence of CK-MB elevation compared to the stent alone. This may be due to improvements in RA technique and a slightly higher incidence of side branch occlusion in the stent group.

4:30

**860-3 Does the Magnitude of Creatine Kinase Elevation Impact Survival in Non-Q Myocardial Infarction After Coronary Interventions?**

Z. Ghazzal, P. Chalasani, Y. Shen, N. Chronos, S.B. King, III, W.S. Weintraub. Emory University Atlanta, GA, USA

Elevations of creatinine kinase (CK) after angioplasty has been shown to have an adverse outcome. In this study we focused on the relation of the magnitude of CK elevation to survival. Patients who underwent angioplasty were divided into four groups: Group I (CK  $< 250$  mg/dl; n = 14034); Group II (CK 250-500 mg/dl; n = 6740); Group III (CK 500-750 mg/dl; n = 185); Group IV (CK  $> 750$  mg/dl). Patients with Q wave MIs complicating angioplasty were excluded. Survival was not decreased until CK was above 500 mg/dl (left figure). The increased mortality related to CK elevation was limited to patients having vein graft procedures (right figure). CK elevation  $> 750$  mg/dl was noted in 3.7% of vein graft procedures vs 2.6% of native vessel procedures ( $p = 0.02$ ). CK elevation was much more common in patients with procedural complications (acute closure, side branch closure or distal embolization (19%) vs an uncomplicated procedure (0.27%,  $p < 0.0001$ ).

**Conclusions:** 1. Elevation of CK post PTCA above 500 mg/dl has a negative impact on survival, but only in patients with vein graft procedures.

TUESDAY MORNING