lowed prospectively for cardiovascular events after screening for baseline cardiovascular risks and cTnI. Patients who had suffered any acute coronary event within the preceding 30 days were excluded from the study.

Results: A total of 100 and thirty seven patients were enrolled (mean age 65 years, 52% males). Of these 73% (10/37) had elevated cTnI levels when a cutoff of >1.0ng/ml was used. Checking for other known cardiovascular risk factors (age, diabetes, hypertension, family history of coronary artery disease, smoking, sex, CKP, homocys-
tetra), at 6 months 40% of patients with cTnI>1.0ng/ml had an event while 8% of those with normal cTnI levels had an event (OR = 9.7, CI = 1.9 - 50.6, p < 0.01). At one year the event rate was 60% vs. 16.5% respectively (OR = 4.1, CI = 1.5 - 11.5, p <0.01).

Conclusions: Our study of stable chronic hemodialysis patients shows a high incidence of cardiovascular events in all subjects in long-term follow-up, especially in those with ele-
vated baseline cTnI levels. However, the additional cardiac risk conferred by an elevated cTnI level in this population may warrant an even more aggressive approach to risk factor modification and this should be the basis for further studies.

2:30 p.m.

861-3

The Influence of Acute Coronary Syndromes on Comparative Changes in Functional Status at 6 and 12 Months Following CABG and PCI: Results From the SOS Trial

Zifeng Zhang, On Behalf of SOS Investigators, Emory University, Atlanta, Georgia.

Background: The SOS trial compared CABG vs. PCI with stent in patients (pts) with multi-vessel coronary artery disease. Previous results reported significant improvement in health status using the Seattle Angina Questionnaire (SAQ) for both treatment arms at 6 and 12 months, with increased benefit for CABG pts. It is not known whether these results apply to pts with and without acute coronary syndromes (ACS). Methods: The SAQ assesses 5 domains: physical limitation (PL), angina stability (AS), angina fre-
quency (AF), treatment satisfaction (TS) and disease perception (DOL), and was admin-
istered at baseline, 6 and 12 months. Higher scores indicate better functioning. Analysis of covariance was used to compare improvements in SAQ scores according to treatment and ACS adjusting for baseline SAQ scores and other factors.

Results: 24.5% of SOS pts had ACS at randomization. There were more women and higher rates of prior MI, class IIIIV angina and current smokers among pts with ACS. Pts with ACS had lower AF, AS and QOL scores at baseline. There was a significant interac-
tion between treatment arm and ACS, whereby pts without ACS who underwent CABG
had greater improvements in all but the TS domain than PCI counterpart, at both 6 and 12 months. Among pts with ACS, improvements in SAQ scores tended to be similar for both treatment arms.

Conclusions: For pts with multi-vessel disease, the greater improvement in health status for CABG vs. PCI is largely limited to pts who do not have ACS.

The Estimated Mean Difference in SAQ Scores According to Treatment Arms and ACS

<table>
<thead>
<tr>
<th></th>
<th>CABG</th>
<th>PCI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PL</td>
<td>13.7</td>
<td>16.5</td>
<td>&lt;0.002</td>
</tr>
<tr>
<td>AS</td>
<td>35.7</td>
<td>40.7</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>AF</td>
<td>30.6</td>
<td>36.4</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>TS</td>
<td>1.2</td>
<td>1.8</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>GOL</td>
<td>26.2</td>
<td>28.4</td>
<td>&lt;0.0004</td>
</tr>
<tr>
<td>1-year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PL</td>
<td>14.8</td>
<td>17.4</td>
<td>&lt;0.006</td>
</tr>
<tr>
<td>AS</td>
<td>41.4</td>
<td>41.3</td>
<td>36.2</td>
</tr>
<tr>
<td>AF</td>
<td>33.6</td>
<td>35.8</td>
<td>&lt;0.005</td>
</tr>
<tr>
<td>TS</td>
<td>3.7</td>
<td>3.6</td>
<td>4.9</td>
</tr>
<tr>
<td>GOL</td>
<td>31.9</td>
<td>33.6</td>
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</table>

2:45 p.m.

861-4

Prediction of Risk in Patients With Unstable Angina and Non-ST-Elevation Myocardial Infarction: A Prospective Comparison of the New ACC/AHA Guidelines and Physician Predicted Risk


Background: Recently published ACC/AHA guidelines for the management of patients with unstable angina and non-ST-segment elevation myocardial infarction (MI) provide parameters for graded advice on short-term risk of death or MI. These parameters are used to determine eligibility for certain newer treatments. Their performance in actual practice settings is not well studied.

Methods: We prospectively evaluated 215 consecutive patients admitted for symptoms suspicious for myocardial injury. The presence of each published guideline risk factor was determined by medical record review. Serial ECGs were interpreted in blinded fash-
on. The physicians caring for each patient were asked to give an assessment for 30-day risk of death or MI. The study end point was 30-day death or new non-fatal MI following the index presentation.

Results: Mean age was 68±11 (97% male). Overall 91% of patients had at least one

high-risk feature by the ACC/AHA guidelines compared to 48% when only the ECG and cardiac marker criteria were used. The physicians initially assessed the patients ident-
fied only 13% of patients as being high-risk. During follow up 24 patients (11%) had events (18 deaths, 6 MI). In univariate analysis, only accelerating tempo of ischemic symptoms (p=0.03), pulmonary edema due to ischemia (p=0.0001) and physician esti-
mate of high risk (p<0.0001) predicted events. In multivariable analysis only pulmonary edema due to ischemia (p=0.015, OR = 5.1, 95% CI = 1.3 - 19.9) was a predic-
tive events of physician. Judgement had higher positive predictive value (44%) than either the guidelines (10%) or a subset of the guidelines including only mark-
er predictors (2%). While all three assessments provided high negative predic-
tive value, physician prediction was slightly better (93%) than the guidelines (89%) or the marker/ECG subset (91%).

Conclusion: Compared to physician assessment, current guidelines classified many more patients with suspected myocardial injury as being high risk. The low specificity of the guidelines suggests they should be applied only to identify high risk patients. Clinician’s risk assessment appears to be a more reliable predictor of events.

2:30 p.m.

861-5

The Italian National Registry of Coronary Care Units: Initial Results From an Internet Based, Patient-Care Oriented Data Management Tool

Marco Tubaro, Luigi Badano, Antonio Falcone, Ennio Neti, Christian Pristipino, Massimo Zoni-Berisso, Domenico Cianflone, on behalf of GBCardio-ANMCO, Project Coordination, Rome - Florence.

Background: Conventional multicenter surveys and registries impose additional workload to the healthcare provider who may not find the relevance of the collected data due to an uneven distribution/selection of participating centers. To overcome these limita-
tions we developed and tested an internet based Registry of coronary care units (CCUs) relying on a "point-of-care" approach to the collection of individual patient data.

Methods: In the framework of the National Cardiovascular Database, the GiCESco- ANMCO Project, we developed a tool for the collection of clinical data for patients admitted to CCUs and for generating discharge summaries. The application was developed with SQL development tools and manages the collection of >250 core data elements, including key core elements for diagnostic and intervention procedures performed to CCU patients. The application and a secure internet access to the National Database Server, which con-
solidates all the peripheral databases, were progressively provided to the 130 participating CCUs. In the timeframe november 2000 - july 2001, 43 CCUs participated in the testing phase. Data from 5573 patients were uploaded and analysed to assess the feasibility of this approach.

Results: Most frequent reason for admissions were as follows: 2206 AMI (66% ST-eleva-
tion MI, 22%non-ST-Elevation, 2% Undetermined), 1241 Unstable Angina (57% in ≥ 3B Braunwald class), 483 chest pain of unknown origin, 487 congestive heart failure (53% acute pulmonary oedema), 413 severe arrhythmias (69% advanced AV block). The analysis of AMI data showed among other items: 36% AMI were preceded by UA; 17% of patients had no major risk factors 61% did not undergo any repercussion strategies. The analysis of UA data showed that 93% of patients were on aspirin (of the remaining 17% only 1.5% did not take any antplatelet nor heparin) and a 16% incidence of elevated troponins.

Conclusions: This "point-of-care" approach to data collection for registries and surveys is feasible and reliable. The shifting of the workload and costs of data collection for outcome research and health surveys to the actual patient care opens the way to larger and more accurate registers.

3:15 p.m.

861-6

Frequency of Use and Cost Implications of Complementary and Alternative Medicine Among Acute Coronary Syndrome Patients


Background: Complementary and Alternative Medicine (CAM) use is increasing in patients admitted for acute coronary syndrome (ACS). The prevalence, type, and the reasons for CAM use in ACS patients are currently unknown. Little information exists on the cost implications of CAM use.

Methods: We evaluated 145 patients discharged alive from the University of Michigan Health Systems after admission for ACS between August 2000 to January 2001. Clinical information was obtained retrospectively using medical records. Six months later, a standardized questionnaire was distributed to determine average CAM use. Food supplement prices were calculated using an average price from five area stores, while practitioner determined CAM therapy prices were obtained through a survey of providers.

Results: Of the 145, 73.8% used CAM (mean age 64 years, discharge diagnosis of AMI 55%, males 67%). Food supplements, vitamins and herbs were the most commonly used CAM therapy (80%). Mind-body techniques were second (25%), of which prayer was the leading therapy (25% of all users). Other CAM included body-based methods (22%), of which chiropractic was used 17%; energy-healing (4%) and chelation therapy (3%). Among CAM users, symptom relief was the most common reason for starting CAM (60%). Most users learned about CAM from family or friends (54%), while (36%) learned about it from a health care professional. When asked their biggest concerns about CAM, 33% of users stated "lack of effectiveness," 21% stated "additional financial burden," while 41% had "no concerns." On average, a CAM user spent an additional $10 a month on food supplements. Body-based CAM users spent an average of $204 a month on therapies such as chelation, mind-body, body-based and energy healing techniques.