not show change ESLV. The reduction was however significantly greater in gr A (42.4% vs. 35.7% p<0.05). WMSI decreased in all gr A (P=0.01 vs 0.03 to 1.1±0.02 vs 0.9±0.03, F(1,14)=2.6, p<0.05, A P=0.1, A 3±0.03 to 1.2±0.04, p<0.05), although most in pts allocated to A+P vs A+V (P=0.21 vs A+V 13.3% vs. A+P 14.2% p<0.05). EF increased in all gr A (P=0.05 vs 43.8±3.5 to 56.8±4.2, p<0.05, A=0.1 vs44.5±3.5 to 55.0±3.1, p<0.05, A=0.1 A=19.1 to 51.1±2.1, p<0.05), by 15% in gr B, by 11% in C gr with most benefit in gr A by 25% (p=0.05 in gr A compared to C and E). EA, increased by 26% in gr A and by 18% in gr B, by 16% in gr C compared with initial rate, although only in gr A this was significant, (0.7±0.05 to 1.03±0.03 p<0.05). Echocardiographic response correlated with ESLV (r=0.36, p<0.02), EF (r=0.45, p<0.05), WMSI (r=0.55, p<0.05), E/A (r=0.52 vs 0.01). During 21 days there were 42 end points; 5 (11.9%) in gr A, 11 (26.1%) in gr B, 16 in gr C (38%). The relative risk reduction (RIR) in end point in gr A was 31% (p<0.01) in comparison to gr B, 35% (p<0.01) to gr C.

Conclusion: Combination of A with P and V showed positive effect on ECHO parameters and significantly reduces cardiovascular events.

516 Comparative effects of losartan and losartan colchicines combination therapy in unstable angina patients with hyperuricaemia

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Aims: To investigate the effects of losartan with the same dose combined with colchicine therapy on ECHO-parameters, on levels of markers of inflammation, on patients' quality of life (QoL), and versus losartan alone in unstable angina (UA) patients (pts) with hyperuricaemia. To determine the nature of the relationship between hs-CRP, increased serum uric acid level (UA), death, recurrent angina or nonfatal MI, need for coronary intervention, which occurred in hospitalization.

Material and methods: 46 pts (age 58.8±5.7) with UA randomly assigned to treatment with losartan 50 mg once daily (group I, n=23) or a treatment with losartan at the same dose combined with colchicine 2 mg iv for the first day and then 1mg in every 6 hour for the second day and 1 mg daily for at least 21 days (group II, n=23). The values of hs-CRP and uric acid were analysed at baseline and at 7 day, 21 days after admission pts underwent echocardiography to determine left ventricular end systolic volume (ESELV), wall motion score index (WMSI) and fraction of ejection (EF). The end point was defined as death, recurrent angina or nonfatal MI, need for coronary intervention, which occurred in hospitalization.

Results: In pts with increased levels of hs-CRP serum uric acid levels were shown to be higher in pts with nonfatal MI, need for coronary revascularization (hs-CRP) by 26% in group I, 21% in group II (p<0.05) and observed decreasing of leucocytosis (p<0.05). After 21 day treatment in both groups ESELV, WMSI decreased, EF increased, although in group II pts showed significantly smaller WMSI (3.0±0.04 to 1.1±0.02, p<0.05), decreased ESLV (48±8.1 to 44±3.8, p<0.01), increased EF (46.7±2.1 to 53.0±0.4, p<0.01) compare the baseline characteristics. At the end of observation in group I ESLV decreased by 18%, WMSI decreased by 11%, EF increased by 7%. End-points significantly reduced in group II compare to the group I (12.6±4.2, p<0.05).

Conclusion: When coadministered with colchicine losartan provided significant incremental reduction in hs-CRP, showed positive effect on ECHO-parameters, improved clinical status, reduced endpoints.

517 Myocardial revascularization in patients with ischemic cardiomyopathy and low left ventricular ejection fraction: a comparison between CABG and PCI

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Revascularization in ischemic HEar Failure Trial (REHEAT) is a non-randomized, case-control, prospective study to assess the hypothesis that surgical and percutaneous revascularization in patients with ischemic cardiomyopathy are associated with comparable improvement of LVEF and functional status after 12 month from myocardial revascularization.

Methods: The study population consisted of 141 patients with LVEF<40% and angiographically confirmed coronary artery disease. Primary end-point was improvement of LVEF 12 months after the intervention. Secondary end-points were: in-hospital major adverse events (MAE), length of hospitalization, necessity of ECG treatment after 12 month, one-year survival, one-year event-free survival, angina severity and heart failure severity after 12 months. Case-control study included 55 patients in PCI and 54 in CABG group.

Results: The incidence of 30 days MAE was higher in CABG group (40.7% vs 9%, p=0.0003). The mean duration of hospital stay was shorter in PCI treatment arm (6.8±3.6 days vs 9.2±2.1 p (0.00001)). After 12 month LVEF improved from 31.5±6.2% to 37.5±6.8% in PCI group (p<0.01) and from 33.1±5.1% to 37.5±9.5% in CABG group (p<0.01). The improvement was comparable after PCI and CABG (5.96±7.21 vs 4.38±9.04, p=0.12).

Long term functional status based on treadmill stress test was better after PCI (Student’s t test, p=0.0003), while according to CCS and NYHA classifications was better after PCI (p<0.05) and observed decreasing of NMDL was greater after PCI (6.7±3.2 vs. A+V 13.3% vs. A+P 14.2% p<0.05). The long-term survival was significantly better in PCI patients (Wilcoxon test, p<0.01), The MAE free survival was better after PCI (Cox Mantel test p=0.0013).

Conclusions: In patients with ischemic cardiomyopathy, PCI is associated with a comparable improvement of LVEF as surgical treatment and offers a better 1-year survival than CABG, however the incidence of repeat revascularization is higher in the PCI group.

518 Can we predict acute coronary events by myocardial jeopardy score in patients with natural progression of coronary artery disease

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Background: Myocardial jeopardy score (MJS) is shown to be a potent predictor of stress induced myocardial ischemia, but its relationship with acute coronary events still remains unknown.

Objective: To determine a role of MJS in prediction of acute coronary events (non fatal myocardial infarction and unstable angina pectoris), in patients with natural progression of coronary artery disease (CAD).

Methods: We evaluate 88 pts with CAD (73 single vessel, 15 multi vessel), who underwent exercise stress echo test (Ex: maximal Bruce) and who did not undergo revascularization procedure. MJS was calculated as a product of: (1) myocardial segmental kinetic status in a region of significantly stenosed vessel (scored from 1 to 4), (2) percent diameter stenosis (%DS-scores from 1 to 5), and (3) weighting flow factor for particular localization of lesion.

Results: Follow up period was 46±22 months. Significant univariate predictors of acute coronary events were: MJS, positive Ex and %DS (Table 1).

Conclusions: In patients with natural progression of coronary artery disease, because of the presence of higher amount of potentially ischemic myocardium and moderate coronary artery stenosis. This confirms the need for integrated evaluation of functional significance of coronary artery disease.

Table 1. Cox regresional analysis

<table>
<thead>
<tr>
<th>Variable</th>
<th>Regress. Coef.</th>
<th>95%CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>%DS</td>
<td>-0.004</td>
<td>0.94-0.99</td>
<td>0.007</td>
</tr>
<tr>
<td>MJS</td>
<td>-0.02</td>
<td>0.97-0.99</td>
<td>0.004</td>
</tr>
<tr>
<td>Positive Ex</td>
<td>1.7</td>
<td>0.75-30.5</td>
<td>0.14</td>
</tr>
</tbody>
</table>

519 Predictors of improvement in Left Ventricular Function after stent implantation of chronic coronary occlusion

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Aims: The effect of coronary stent implantation of chronic coronary occlusion on left ventricular (LV) performance is not well known. So, the aim of this study was to assess the effect of stent implantation on LV ejection fraction (EF) and to examine how clinical and angiographic factors may have an effect on recovery of LV EF.

Methods and results: Three hundred and four patients who underwent successful stent implantation for chronic occlusion of a major epicardial coronary artery existing for at least six weeks were included into the study. Echocardiographic examination was performed before and six months after stent implantation. A significant increase in LV EF (53.2±11.9% to 70.2±11.1%, p<0.0001) with a decrease in both LV end-diastolic volume index (85.6±18.9 ml/m² to 80.1±17.1 ml/m², p<0.001) and LV end-systolic volume index (40.0±15.8 ml/m² to 34.1±14.3 ml/m², p<0.0001) after stent implantation of chronic coronary occlusion was observed. Multivariate analysis revealed diabetes mellitus existence, angiotensin converting enzyme use, occlusion duration <3 month and baseline LV EF<50% to be significant predictors of left LV EF improvement during the first 6 months after stent implantation.

Conclusions: Stent implantation for a chronic coronary occlusion has a beneficial effect on LV EF during the first 6 months after the stent implantation,