significant predictors of all-cause mortality (hazard ratios: APN, 5.02; p < 0.001; CRP, 3.43, p < 0.001). The rate of ACS recurrence was significantly associated with APN levels. However, the other biomarkers did not show relationships with ACS recurrence. Multivariate analyses adjusted for APN, age, body mass index, diabetes, hypertension, smoking, and dyslipidemia identified the median and highest tertile of APN levels as the only predictors of ACS recurrence (hazard ratios: median, 4.46, p = 0.024; highest, 6.63, p = 0.005).

Conclusions: Among the established biomarkers related to patient prognosis, APN was the most useful predictor of all-cause mortality and ACS recurrence.

P1316 | BEDSIDE
Troponin T is a strong predictor of mortality in hip fracture patients
P. Hietala, M. Strandberg, N. Strandberg, E. Gullischen, J. Airaksinen. Turku University Hospital, Turku, Finland

Background: The aim of this prospective cohort study was to assess the prognosis of acute myocardial infarction in a series of consecutive hip fracture patients treated surgically.

Methods: A consecutive cohort of patients (n=200, 68 men) referred to an elective surgical correction of hip fracture was studied. In addition to clinical evaluation, troponin T (TnT), and ECG were assessed on admission, before operation and on 1st and 2nd post-operative days. The patients were followed at 30 days, 1 year and 2 years.

Results: The age of the patients ranged from 32 to 98 years (mean age 80.8 years). 65 patients (33%) had a history of coronary artery disease. And 28 (14%) suffered from heart failure. A significant rise in TnT as a sign of myocardial infarction was observed in 71 patients (36%), and 36 (51%) of them had an elevation of TnT already before surgery. 23 (32%) patients had an elevated level of TnT already on admission to hospital, and 35 (49%) developed a TnT elevation post-operatively. Majority of patients with elevated TnT level were asymptomatic. TnT elevations were more common in men, elderly patients, and patients with a history of cardiovascular diseases. The 30-day mortality was 17% in patients with a TnT elevation and 5% in patients with no TnT elevation (p = 0.008). The 1-year mortality was 34% in patients with a TnT elevation and 21% in patients with no TnT elevation (p < 0.05). The 2-year mortality was 48% in patients with a TnT elevation and 31% in patients with no TnT elevation (p = 0.01). Elevated TnT level on admission was a strong predictor of mortality at both 1-month, 6/23 (26.1%) vs. 11/171 (6.4%) (p < 0.007), and 1-year, 11/23 (47.8%) vs. 45/171 (26.3%) (p < 0.048).

Conclusions: Patients with a hip fracture often develop asymptomatic or clinically unrecognized perioperative myocardial infarctions. Elevated level of TnT in hip fracture patients is a strong predictor of mortality at 1-month, 1-year and 2-years. Earlier diagnosis and appropriate treatment of cardiac infarction might improve survival of hip fracture.

Figure 1. Timing of SCA events

Results: Between 2/2010 and 12/2012, 576 unique pts matched study criteria. Pts (age 60±12 years, 85% male) were followed for a median of 51 days. The WCD appropriately treated 13 pts for VT/VF. No asymptole events occurred during use. Resuscitation success was 100%. The median time to SCA was 15 days after initiating WCD use.

Conclusions: SCA occurred in 2.3% of pts having a compromised EF after MI and/or revascularization, and the majority of SCA occurred during the first month of use. The WCD resuscitated 100% of pts that experienced SCA.
matically decreased in the recent past. Whether the previously reported gender disparities in use of invasive strategies (IS) persist and translate into differences in outcomes deserves to be examined.

Methods: We used the data from a nationwide French prospective multicentre registry from 3,670 AMI patients (1155 women (31.5%), 2515 men (68.5%)) recruited in 233 centers in 2005 and followed-up for 3 years. We examined hospital outcomes and 3-year mortality in patients categorized according to gender and use of IS (i.e. coronary angiography during the hospitalisation with a view to revascularisation).

Results: IS was less frequently used in women than in men (adjusted OR=0.66; 95% CI: 0.52-0.85), regardless of the type of AMI, age group or risk category, while use of recommended medications was similar at 48 hours and discharge. In-hospital mortality did not differ according to gender, whatever the age group and use of an IS. At 3 years, overall and post-discharge mortality were similar in men and women. However, IS was associated with lower 3-year mortality (women: HR=0.50; 95% CI: 0.39-0.63) and there was no gender-strategy interaction.

Conclusion: Invasive strategy remains less frequently used in women than in men, yet is associated with improved three-year survival irrespective of gender. Whether reducing the gender gap in its use would translate into a higher survival in women remains an open question.

P1320 | BENCH
Assessing renal function in acute coronary syndromes: does it really matter how we do it?

P. Mendes1, A. Mendes1, R. Ferreira1, H. Martins1, S. Monteiro1, F. Gonçalves1, A. Beto1, P. Monteiro1, G. Mariano Pego1, 1University Hospitals of Coimbra, Coimbra, Portugal; 2Centro Nacional De Dados Em Cardiologia, Coimbra, Portugal

Background: According ESC guidelines renal function should be assessed using estimated Gliomerular Rate Filtration (eGFR) calculated using Modification of Diet in Renal Disease (MDRD) equation, although in daily clinical practice Creatinine Clearance (CrCl) calculated with the Cockcroft-Gault (CG) formula is more often used.

Purpose: To assess if eGFR using MDRD equation has more prognostic impact than CrCl calculated with CG formula in acute coronary syndromes (ACS).

Population: 2076 patients admitted for ACS between 2004 and 2011 in a Coronary Care Unit. Primary endpoint was death or myocardial infarction in the follow-up.

Results: The mean age of patients was 68±13 years and 67.5% were male. Approximately one third of study population (30.5%) had diabetes, 35.6% were elderly and 74.5% had hypertension. Regarding type of ACS, 39.5% of patients had ST elevation; 29.8% of patients reached the primary endpoint in the follow up. Mean admission creatinine was 1.22±0.87 mg/dL. Mean eGFR was 70.82±25.91 mL/min/1.73m² and mean CrCl was 70.87±32.98 mL/min. Using MDRD equation, 6.7% of patients had eGFR <30 mL/min/1.73m²; otherwise, using CG formula, 9.0% of patients had CrCl<30.0 mL/min. Comparing both equation the Concordance Correlation Coefficient was k=0.629 and Spearman Correlation Coefficient was 0.872, with great discrepancy for higher eGFR values. Area under the curve (AUC) of MDRD ROC curve was 0.613 (0.586; 0.639), p<0.001, while AUC of CrCl was 0.614 (0.587; 0.640), p=0.001. Comparing both ROC curves p value was not statistically different (0.888).

Conclusion: In ACS patients, renal function has an important prognostic value. Although ESC guidelines recommend MDRD formula, CrCl using CG formula has the same prognostic value regarding death or myocardial infarction.

P1321 | BEDSIDE
The prognostic value of discharge heart rate in patients with impaired left ventricular function after acute myocardial infarction

T. Hoshi1, A. Sato1, M. Kawabe1, S. Saki1, Y. Kakefuda2, D. Abe3, N. Takeyasu4, Y. Nogushi5, K. Azuma1, 1Cardiovascular Division, Faculty of Medicine, University of Tsukuba, Tsukuba, Japan; 2Department of Cardiology, Tsukuba Medical Central Hospital, Tsukuba, Japan; 3Department of Cardiology, Ibaraki Prefectural Central Hospital, Kashiwazaka, Japan.

Objectives: Heart rate (HR) has demonstrated to be a prognostic value in AMI patients. However, it is unclear whether HR is still secure regardless of left ventricular (LV) function. We investigated the association between clinical prognosis and discharge HR in acute myocardial infarction (AMI) patients who were stratified by LV function.

Methods: A total of 1175 AMI patients who underwent PCI, except for in-hospital death, were analyzed from ICAS (Ibaraki Cardiovascular Assessment Study) multi-center registry. Analyzed subjects were divided by resting HR at discharge (quartiles) and LV ejection fraction (≥50% or <50%). Major adverse cardiovascular endpoint (MACE) was defined as a composite endpoint of all-cause mortality, myocardial infarction, stroke, or heart failure.

Results: MACE was observed in 131 patients (11%) during median follow-up period of 496 days, and there was a stepwise increase in MACE with increasing HR. Among the group with impaired LV function, high HR was significantly associated with increased risk of MACE (3.4- and 5.2-fold, for HR quartiles ≥75 bpm and quartile 4 [<75bpm], respectively). Multivariate Cox regression analysis showed that discharge HR remained to be an independent predictor of MACE (hazard ratio [every increase of 5 bpm] 1.10, 95% confidence interval 1.04-1.18, p=0.003).

Conclusion: Resting HR at discharge was a significant predictor of MACE after AMI, especially in the patients with impaired LV function.

P1322 | BEDSIDE
Incremental value of admission blood glucose on top of GRACE risk score in patients with acute coronary syndromes

A.T. Timoteo1, A.L. Papalia2, P. Rio1, F. Miranda1, M.L. Ferreira1, R. Cruz Ferreira1, 1Hospital Santa Marta, CHLC, Lisbon, Portugal; 2New University of Lisbon, Faculty of Medical Sciences, Lisbon, Portugal

Background: Abnormal glucose metabolism is a predictor of worse outcome after Acute Coronary Syndrome (ACS). However, this parameter (or the presence of diabetes), isn’t included in the most recently risk prediction scores, including GRACE risk score. We sought to evaluate if the inclusion of blood glucose on admission in a model with GRACE risk score improves risk stratification.

Methods: Study of consecutive patients included in a single centre registry of ACS. We clinical and laboratory variables as well as treatment provided. Primary endpoint was the occurrence of all-cause mortality at one-year follow-up. The ideal cut-off of blood glucose to predict the outcome was obtained by receiver-operating characteristics (ROC) curve analysis. Predictive value of high blood glucose was assessed by Cox regression analysis. The incremental predictive value was analysed with ROC curve, Net Reclassification Improvement (NRI) and Integrated Discrimination Improvement (IDI) of logistic regression models obtained with GRACE risk score alone and after the inclusion of blood glucose.

Results: We included 2099 patients, mean age 64±9 years, 69% males. In our population, 55.1% presented with ST-segment elevation ACS and 13.1% in Killip class ≥2. Only 25% were known diabetic at admission. In-hospital mortality was 5.8% and 9.7% at one-year follow-up. The best cut-off for blood glucose was 160 mg/dL (sensitivity 62% and specificity 68%), and 35.2% of the patients had increased levels. This group was elderly, had more prevalence of cardiovascular risk factors, worst renal function and GRACE score as well as more frequently Killip class ≥2. Treatment was similar in both groups but the hyperglycemia group had higher in-hospital mortality (11.2% vs. 2.8%) and at one-year follow-up (17.2% vs. 5.6%). Log-rank (p<0.001). Hyperglycemia on admission is a predictor of death independently of the GRACE risk score and the presence of diabetes (HR 1.89, 95% CI 1.38 – 2.58, p<0.001). Inclusion of this parameter in a regression model with GRACE score increased the Area Under Curve from 0.804 to 0.816 (p<0.038). The new model was associated with an improvement in both the Net Reclassification Improvement (NRI = 60%) and the Integrated Discrimination Improvement (IDI = 0.015) suggesting effective reclassification.

Conclusions: A blood glucose level on admission ≥160 mg/dL is an independent