nents included in the risk chart were age, critical limb ischaemia, diabetes, and a prior vascular intervention. The overall performance of the risk chart was fair with a Brier score of 0.19. ROC analysis showed good discriminatory performance of the risk chart with an area under the curve of 73%. The Hosmer-Lemeshow statistic (chi-squared 13.56; p=0.851) in combination with the calibration curve showed a good calibration of the risk chart.

Conclusions: Our risk chart proves to be a valid tool for the prediction of mortality and major cardiovascular events in patients after peripheral bypass surgery and may serve as a tool for individualised care of patients with severe PAD.

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Cardiovascular function and comorbidities in elderly subjects with COPD
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Purpose: The mechanisms underlying pathogenetic interactions between chronic obstructive pulmonary disease (COPD) and cardiovascular disease (CVD) are largely unknown despite a clinical mutual association in causing mortality and morbidity. Besides smoking, obesity and systemic inflammation share the major CV events and being causative factors for both CVD and COPD. The present study aims to investigate, in an unselected, community-dwelling, elderly population, possible relationships between lung and cardiovascular impairment.

Methods: A screening questionnaire was administered to 500 subjects aged from 65 to 84 years, randomly selected from the general population of Verona. All candidates with the subjects underwent conventional 2-dimensional pulmonary function test and a diagnostic cardiovascular study (Echocardiography, carotid Echo-Color-Doppler and Ankle-Brachial-Index). Blood pressure (BP), body mass index (BMI) and biochemical markers of inflammation were routinely obtained from all the participants.

Results: COPD vs non-COPD patients differ for age (mean age: 70 vs 67 years) but not for BP (mean: 130/80 vs 130/82 mmHg), BMI (mean: 28 vs 27 g/m2), total cholesterol (mean: 192 vs 220 mg/dL) and glycaemia (mean: 102 vs 97 mg/dL). In COPD patients, a greater extension of total cholesterol (p=0.009) and patients with type A acute aortic dissection (p=0.010) had high CRP levels. COPD patients related to control patients present: pathological left ventricle (3.7%), greater extension of atherosclerotic burden (mean number of carotid plaques: 2.6 vs 1.2) and higher level of plaque calcification.

Conclusions: Magnitude of changes in the cardiac structure and function is related to the severity of COPD. COPD patients show a great prevalence of peripheral vasculopathy and a typical pattern of cardiac and vascular remodelling that expose them to high cardiovascular risk. In particular the mechanical reduction of cardiac outflow linked to hyperinflation state, vascular tone regulation and stiffness due to O2 blood pressure variation and the great atherosclerotic tendency of cardiac outflow linked to hyperinflation state, vascular tone regulation and stiffness due to O2 blood pressure variation and the great atherosclerotic tendency have to be taken into account in the evaluation of COPD patients.

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Inflammatory markers and the risk of vascular complications and mortality in type 2 diabetes mellitus
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Purpose: There are few data assessing the relationship between circulating levels of C-reactive protein (CRP), fibrinogen, and interleukin-6 (IL-6) and the risk of vascular complications in individuals with type 2 diabetes mellitus (T2DM). We studied the associations between these inflammatory markers and the risk of major CV events (CV death, myocardial infarction or stroke), microvascular complications and death in patients T2DM who participated in the Action in Diabetes and Vascular Disease: Preterax and Diamicron Modified Release Controlled Evaluation (ADVANCE) trial.

Methods: Baseline high sensitivity CRP, fibrinogen and IL-6 levels were determined in a case-cohort study (n=3,865), nested within the ADVANCE trial.

Results: During 5 years of follow-up, 709 patients suffered a major CV event, 439 a microvascular complication and 706 died. All 3 markers were associated with an increased risk of CV event and death in analyses adjusting for age, sex and treatment groups. After further adjustment, for other potential confounders and for each other, only IL-6 was an independent predictor of these outcomes (hazard ratio [HR] for CV events 1.37 per 1 standard deviation [SD] increase in log IL-6, 95% confidence interval [CI] 1.34-1.51; HR for death 1.35, 95% CI 1.23-1.49). This increased hazard was seen in patients with and without prior CV disease (figure, HR per 1 SD increase in log IL-6). IL-6 significantly improved the prediction of CV events and death using reclassification statistics (net reclassification improvement in continuous models 23% for CV events and 30% for death). After adjustment, none of the markers predicted microvascular complications.

Conclusions: IL-6, but not CRP or fibrinogen, levels add significantly to the prediction of CV events and mortality in individuals with T2DM.

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The prevalence of non-fatal adverse cardiovascular events among young patients with multiple abnormalities of connective tissue: 7-year follow-up
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Purpose: Hereditary connective tissue diseases (Marfan syndrome, Ehlers-Danlos syndrome, Loeys-Dietz syndrome, osteogenesis imperfecta and etc.) are risk factors of aortic aneurysm/dissecection, intercostal and subclavian aneurysms, myotomy and sudden cardiac death. We aimed to investigate the incidence of non-fatal adverse cardiovascular events among young patients with multiple connective tissue abnormalities and the risk factors associated with non-fatal adverse cardiovascular events in patients with multiple connective tissue abnormalities.

Methods and results: A total of 547 relevant patients observed in the course of 7 years (mean age 28.9±9.7, 39.5% female). The most frequent connective tissue abnormalities were presented the following characteristics: dilothostenomala (31.44%), flat feet (40.22%), hyper-flexible joints (24,31%), deformities of the spine (77,15%), deformity of the anterior wall of the chest (38.21%), weak muscle tone (32,36%), skin abnormalities (43,14%), mitral, aortic or tricuspid valve prolapse (46,43%), vescisntrocity (22,67%), dilatation of ascending aorta or pulmonary artery (8,98%), primary spontaneous pneumothorax (21,02%), congenital malformations (45,7%).

Results: Non-fatal adverse cardiovascular events were registered in 25.57% cases during the observation period: arythmyia including lone atrial fibrilation (3,47%), transient ischemic attack (0,18%), spontaneous dissection of the carotid artery (0,18%), rupture of the chordate tendineae (0,18%), documented coronary insufficiency due to the anomalies of the arteries (0,18%), progressive failure of the mitral valve requiring surgical intervention (1,46%), lone pulmonary thromboembolium (0,18%), subarachnoid hemorrhage due to rupture of cerebral artery aneurysms or arteriovenous malformation (6,40%), symptomatic cerebral arterial aneurysms or arteriovenous malformations (10,42%, except cases of subarachnoid hemorrhage), aortic aneurysm/dissecection requiring surgical interven- tion (2,95%).

Conclusions: Severity of the clinical spectrum of connective tissue disorders is highly variable. Light phenotypic manifestations of connective tissue abnormalities are often underestimated in the contest of the risk of complications. Young patients with multiple connective tissue abnormalities is a group of risk of adverse cardiovascular events and require careful monitoring of cardiovascular system in the stage of life despite the absence of hereditary syndromes.

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Predictors of long-term outcomes in patients with medical treatment for acute aortic dissection
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Background: Although uncomplicated acute aortic dissection can be managed with aggressive medical therapy, long-term outcomes of patients with medical treatment for either type A or B dissection have not been fully investigated. This study was designed to evaluate outcomes and identify prognostic predictors in patients with medical treatment for acute aortic dissection.

Methods and results: We examined 85 patients (60 males; mean age 67.8 years) with acute aortic dissection, which was classified Stanford type A or B and followed conservatively for a median period of 6.7 months. To analyze adverse events (death or any aortic events requiring open surgery or endovascular intervention), Kaplan-Meier event-free curves with log-rank tests were performed (Figure 1). Significantly high event rates were observed in females (p=0.011), and in patients with ulcer-like projection (p=0.004). Moreover, patients with estimated glomerular filtration ratio (eGFR) below the median level of 65.6 mL/min/1.73m² (p=0.009) and patients with type Y acute aortic dissection (p=0.010) had higher risk of adverse events. Cox proportional hazard models demonstrated that females (HR 4.93, 95% CI: 1.73-14.03, p=0.003), below the median eGFR (HR 5.72, 95% CI: 1.43-21.85, p=0.012), and the presence of ulcer-like projection (HR 3.24, 95% CI: 1.11-9.44, p=0.001) were strong predictors for adverse events; on the contrary, the Stanford classification was not significant after multivariate ad- justments.