**Table 1. Corrected values of the QTp, QTe and Tp±Te intervals in the HT/NC cardiomyopathy patients.**

| | QTp (ms) | QTe (ms) | Tp-Te (ms) |
|---|---|---|---|
| Lead I | 274±29* | 363±32 | 90±14* |
| Lead II | 274±29* | 364±30 | 95±33 |
| Lead III | 279±30* | 367±31 | 88±13 |
| aVR | 274±29 | 366±31 | 91±13 |
| aVL | 277±31* | 367±34 | 92±12 |
| aVF | 276±28* | 370±32* | 94±12 |
| Lead V1 | 94±12 | 368±32 | 92±13 |
| Lead V2 | 281±29† | 375±34 | 95±14† |
| Lead V3 | 281±30† | 374±31 | 93±13† |
| Lead V4 | 280±30* | 375±29 | 95±12† |
| Lead V5 | 279±29* | 373±30 | 95±12† |
| Lead V6 | 279±35* | 373±33 | 92±13† |

*P<0.05 and †P<0.001

**Table 2. Corrected values of the QTp, QTe and Tp±Te intervals in the controls.**

| | QTp (ms) | QTe (ms) | Tp-Te (ms) |
|---|---|---|---|
| Lead I | 251±24 | 352±24 | 101±11 |
| Lead II | 257±23 | 358±25 | 99±12 |
| Lead III | 254±26 | 348±31 | 93±16 |
| aVR | 261±25 | 356±31 | 96±18 |
| aVL | 252±27 | 349±39 | 95±16 |
| aVF | 260±25 | 350±36 | 91±18 |
| Lead V1 | 268±30 | 368±34 | 99±16 |
| Lead V2 | 249±27 | 358±35 | 109±14 |
| Lead V3 | 251±26 | 362±33 | 111±12 |
| Lead V4 | 254±27 | 367±34 | 113±11 |
| Lead V5 | 261±30 | 367±30 | 111±13 |
| Lead V6 | 256±22 | 364±29 | 109±17 |

## PP-154

### Effects of Coronary Collateral Circulation on Tp-e interval, Tp-e/QT and Tp-e/QTc Ratios in Coronary Artery Disease Patients

*Hakan Taşolar[1], Ömür Otlu[2], Adil Bayramoğlu[2], Mehmet Ballı[1], Mustafa Çetin[1], Burak Altun[3], Hasan Pekdemir[2], Ramazan Özdemir[2]*

*[1]Adiyaman University Training and Research Hospital, Department of Cardiology, Adiyaman, [2]Inonu University Faculty of Medicine, Turgut Ozal Medical Center, Department of Cardiology, Malatya, [3]18 Mart University, Faculty of Medicine, Department of Cardiology, Canakkale*

**Background:** Coronary collateral circulation (CCC) identifies the severity of ischemic myocardial injury. Tp-e/QT ratio and Tp-e/QTc ratio are known as indicators of ventricular arrhythmogenesis. Aim of our study was to assess the effect of CCC on ventricular arrhythmogenesis in coronary artery disease patients using these new markers.
**Methods:** Fifty five patients who have at least one occluded major coronary artery were included in our study. Study population were divided into two groups according to the Rentrop collateral scoring system with poor (Rentrop score 0-1, n=26) and good (score 2-3, n=29) CCC. We collected fasting blood samples before the coronary angiography.
**Results:** QT dispersion (QTd) (27.8±4.5, 25.6±3.9 P=0.011), corrected QTd (33.3±7.4, 30.8±5.8, P=0.017), cTp-e interval (84.5±7.5, 72.0 ± 5.7, P<0.001), Tp-e/QT (0.26±0.03, 0.18±0.03, P<0.001) and Tp-e/QTc ratios (0.21±0.02, 0.15±0.03, P<0.001) were significantly higher in good CCC patients compared to poor group. We found significant positive correlations between the collateral score with Tp-e/QT and Tp-e/QTc ratios (r=0.444, P<0.001, r=0.418, P<0.001, respectively).
**Conclusıon:** We found higher cTp-e interval, Tp-e/QT and Tp-e/QTc ratios in patients with good CCC than in poor CCC. We consider that cTp-e interval, Tp-e/QT and Tp-e/QTc ratios are likely to be useful indices of ventricular arrhythmias in coronary artery disease patients, especially who have good CCC.

## PP-155

### Evaluation of Heart Rate Turbulence Parameters According to Localization of Infarction in Patients with ST-elevation MI who Underwent Primary Percutaneous Coronary Intervention

*Özge Özcan Abacıoğlu[1], Harun Kılıç[3], Ramazan Akdemir[3], Ekrem Yeter[2], Mustafa Gökhan Vural[4], Sadık Açıkel[2]*

*[1]Zonguldak Atatürk State Hospital, Zonguldak, [2]Ministry of Health Dışkapı Yıldırım Beyazıt Research and Educational Hospital, Department of Cardiology, Ankara, [3]Sakarya University School of Medicine, Department of Cardiology, Sakarya, [4]Kastamonu Münif İslamoğlu State Hospital, Kastamonu*

**Objectıve:** We aimed to evaluate heart rate turbulence (HRT) parameters according to localization of myocardial infarction (MI) in patients with ST-elevation MI who underwent primary percutaneous coronary intervention and determine if these parameters should be used for prognosis and if they effect in-hospital mortality.
**Methods:** Our study included a total of 48 patients who underwent primary percutaneous coronary intervention (PTCA) after acute ST-elevation MI and were divided in two groups as anterior and inferior due to localization of infarct. The exclusion criterias were; history of coronary artery bypass grafting, previous coronary intervention, trombolytic therapy, atrial fibrillation in electrocardiogram (ECG), presentation with only lateral or posterior infarction. 24 hours ECG holter monitoring was executed for all patients and records were analyzed with holter program. TO (turbulence onset) and TS (turbulence slope) were measured by Schmidt criterias. For TO >0% and TS< 2.5 ms / RR values were considered pathological. Data analysis was performed using SPSS for Windows 11.5 package program. p<0, 05 was considered to be statistically significant.
**Results:** According to the localization of infarction in MI groups in terms of age and gender differences were not statistically significant (p=0, 460 and p=1, 000) (Table 1). Mean left ventricular ejection fraction (LVEF) of anterior MI group was significantly lower than those of inferior MI group (p<0, 001). TO and TS levels didn't differ statistically significant between groups (p=0, 483 and p=0, 733) (Table 2) (Figure 1-2). 9 patients (18.7%) had abnormal TO, whereas the values of TS were normal in all patients. TS levels were significantly lower in DM group (p=0, 023) although TO showed a statistically nonsignificant change (p=0, 273) (Table 3). There was a significant correlation between age and TS, TS levels were decreasing with age (r=-0, 335 and p=0, 020).
**Conclusıon:** There has not been a study investigating the parameters of HRT according to localization of MI so far. HRT values were similar between the groups and we could not find any connection between HRT parameters and LVEF. A statistically significant negative correlation between TS and age was found in our study too. According to our results, HRT parameters which can be used as a predictor of mortality after myocardial infarction do not appear to be a sensitive method in determining the risk at early period when they are used for the groups divided due to localization. In our study, mean LVEF levels of patients included in the study were high and the deterioration rate of HRT parameters was low due to be treeated with primary percutaneous intervention and this may have played a role in detection of these results. Prospective studies on larger patient groups are needed to demonstrate the relationship between HRT and acute myocardial infarction and effects of these parameters at short and long-term prognosis.