

Microalbuminuria during acute myocardial infarction

A strong predictor for 1-year mortality

G. Berton¹, R. Cordiano², R. Palmieri², F. Cucchini³, R. De Toni⁴ and P. Palatini⁴

¹Division of Cardiology, Conegliano General Hospital; ²Division of Internal Medicine, Adria General Hospital; ³Division of Cardiology, Bassano del Grappa General Hospital; ⁴Clinica Medica 4, University of Padova, Padua, Italy

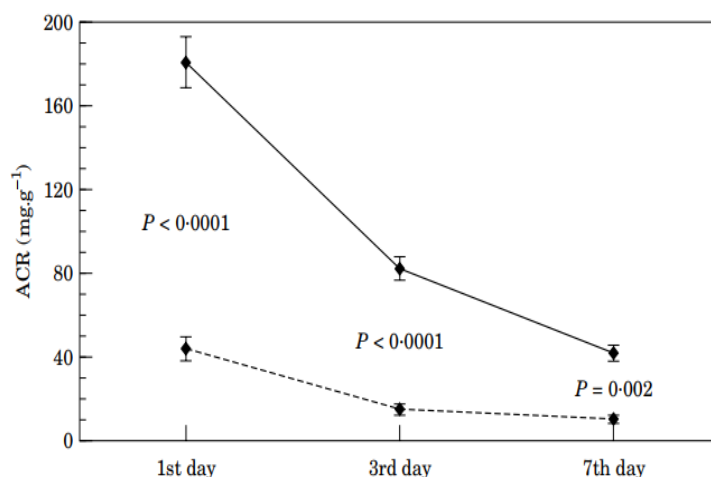


Figure 1 Urinary albumin:creatinine ratios measured on the first, third, and seventh days after admission to hospital for myocardial infarction. Data of 77 patients who died (—) during the year of follow-up and 355 survivors (---) were compared by repeated-measure ANCOVA adjusting for age, gender, presence of diabetes, creatine-kinase-MB peak, heart failure, ACE-inhibitor and thrombolytic therapy (P for ANCOVA <0.0001). Values are means and error bars indicate SEM. ACR=albumin:creatinine ratio.

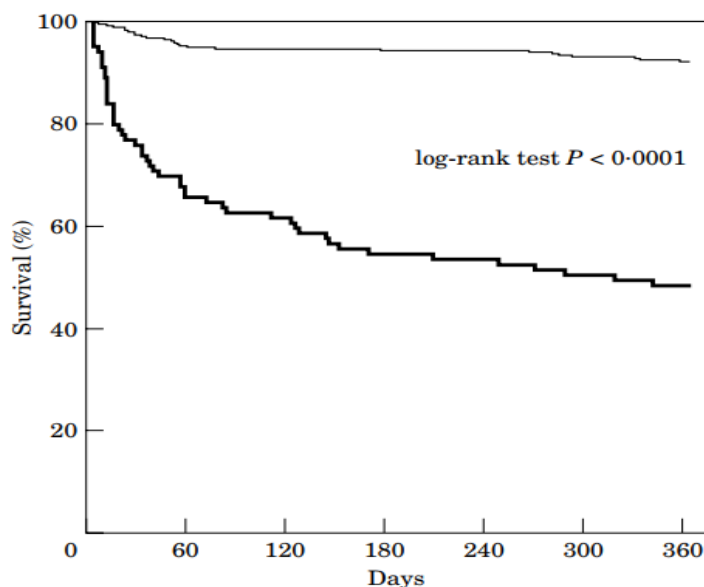


Figure 2 Kaplan–Meier estimates of the probability of 1-year all-cause mortality in the patients stratified by urinary albumin:creatinine ratio $\geq 30 \text{ mg} \cdot \text{g}^{-1}$ or $< 30 \text{ mg} \cdot \text{g}^{-1}$ on the third day after admission (P for log-rank test <0.0001). ACR=albumin:creatinine ratio. — = albumin:creatinine ratio $< 30 \text{ mg} \cdot \text{g}^{-1}$ ($n=333$); - - - = albumin:creatinine ratio $\geq 30 \text{ mg} \cdot \text{g}^{-1}$ ($n=99$).