

Similar to reported data, we found also that MPV was significantly higher in MI group than UA group (1, 2, 6, 17) but unlike the result of Mc Karns et al ⁽³⁾ and in contrast to finding of Mathur et al (21) who observed higher MPV in UA group than MI group. Similarly, it is noted that the time span between MI and laboratory testing did not influence platelet size and thus may suggest that MPV will not change during the acute phase reaction. The finding of this study confirm that increased MPV might be responsible for the prothrombotic state that eventually leads to thrombus formation after rupture of coronary plaque (10,16,21).

Little is known about the effect of aspirin and other platelets aggregation inhibitors on MPV (10), however, whether intervention with platelets aggregation inhibitors or other drugs are beneficial for patient with high MPV remain to be determined.

Conclusion

MPV might be a valuable risk factor for atherosclerosis and acute coronary syndrome. Since it is simple, economic & practical, MPV & P-LCR can be used in predicting the possibility of acute thrombosis in patients with coronary artery diseases.

Table 1: Demographic & clinical characteristics in the study population

Character		UA		MI		P value
		No	%	No	%	
Sex	Male	4	28.6	12	54.5	0.126
	Female	10	71.4	10	45.5	
Smoking	yes	-	-	8	36.4	0.011*
	no	14	100.0	14	63.6	
Diabetes mellitus	yes	10	71.4	14	63.6	0.629
	no	4	28.6	8	36.4	
Hypertension	yes	14	100.0	16	72.7	0.032*
	no	-	-	6	27.3	
History of CAD	yes	10	71.4	14	63.6	0.629
	no	4	28.6	8	36.4	
Cardiac Enzyme	Positive	2	14.3	18	81.8	0.0001*
	Negative	12	85.7	4	18.2	

*The Pearson Chi-Square statistic is significant at the 0.05 level.