to evaluate prognostic value of NT-proBNP level and GRACE score. The logistic regression models were used to assess the prognostic contribution of NT-proBNP level and GRACE score.

**Results** During the follow up, 14 primary endpoints were recorded including nine recurrent ischaemia or myocardial (64.3%), two unplanned revascularisation (14.3%) and three new onset of congestive heart failure (21.4%) and no cardiac death. The systolic blood pressure was significantly lower while heart rate, left ventricular ejection fraction (LVEF), Killip grading were significantly higher in the endpoints group than in non-endpoints group. The LgNT-proBNP level at admission (mean±SD 2.39±0.56 vs 2.13±0.59) and GRACE score ((mean±SD 162.48±33.15 vs 101.63±30.49) were significantly higher in the endpoints group than in non-endpoints group (all p<0.001). After GRACE risk stratification, LgNT-proBNP of high risk group was the highest among the three groups (p<0.001). According to NT-proBNP levels, patients were stratified into four groups by quartile. Compared with lowest, second, and third quartiles, the GRACE risk score was the highest in the fourth quartile (p<0.001). The LgNT-proBNP in patients with NSTE-ACS had positive correlation with their GRACE risk score (r=0.30, p<0.001).

The prognostic criteria for NT-proBNP level (area under cure, 0.47) was 608 pg/ml determined by ROC (p<0001). For GRACE score, the predictive value for endpoints was 0.718 (p=0.001) and the cut-off point was 156. Addition of NT-proBNP to the GRACE score, the predictive value for endpoints was 0.825 (p<0.001). In the logistic regression model, NT-proBNP and GRACE score were independent predictors of endpoints in the patients with NSTE-ACS.

**Conclusions** Both NT-proBNP level at admission and GRACE score were independent predictors for endpoints at 30 days in patients with NSTE-ACS. The prognostic criteria for NT-proBNP level was 608 pg/ml. For GRACE score, the cut-off point was 156. Plasma NT-proBNP level refine the accuracy of the GRACE score.