Objective. The aim of the study was to identify the factors, associated with poor prognosis in patients with stable coronary heart disease (CHD), and to build a statistically validated model for predicting the risk of mortality and non-fatal cardiovascular events (CVEs) in patients with stable CHD.

Methods. This retrospective observational cohort study included 85 patients, admitted to the Dagestan Center of Cardiology and Cardiovascular Surgery for planned inpatient treatment from 01.01.2015 to 31.12.2017 and with a giagnosis of stable exertional angina. The data were collected from patients' medical records and their long-term outcomes were consequently verified. Simultaneously, a telephone contact was established with enrolled patients to ascertain vital status and to record cardiovascular events. The patients were invited for reassessment, which included clinical and anamnestic data, laboratory and instrumental diagnostics. For the prognostic model, binary logistic regression was used to evaluate the impact of certain factors on the probability of adverse outcomes development.

Results. Over the 4-year period of observation, 5.9% (5 people) of 85 patients died. In 84.7% (72 patients) of all cases, admission due to CHD worsening was registered. In 15.3% of patients (13 people), the primary composite endpoint, which included all-cause mortality and CVE development, was reached. The prognostic model for evaluation of probability of reaching the primary endpoint, depending on the influence of variable factors was built. The most significant factors included: hematocrit, echocardiographic left atrial volume, and coronographic chronic occlusion of the left circumflex artery. The obtained model was proven statistically significant ($p<0,01$), and had high sensitivity (85.7%) and specificity (97.4%).

Conclusion. In this study, certain factors that contribute to the risk of death and non-fatal CVEs in patients with stable CHD were identified. This allowed for the development of a prognostic model to estimate these risks and facilitate the further implementation of secondary prevention measures in clinical practice.