(Nov 2012 - Jan 2013) across the three centres. For all patients the median age was 68 years (58-77), BMI 28 (25-29-YZ) and 246 (69x%) were males. 56 (16%) had unstable angina, 143 (41%) Non ST Segment Elevation Myocardial Infarction and 156 (43%) ST Segment Elevation Myocardial Infarction. 300 (80%) patients had diagnostic angiography, revealing three vessel disease in 30%, and left main stem disease in 12%. 37 (11%) patients experienced a MACE at 30 days, of which 16 (4.5%) died. Of all risk stratification tools tested, only a positive GSF score was significantly associated with adverse events (HR 1.9:1.2-2-9; p=0.03; AUC 0.70), independent of age, left ventricular ejection fraction and diagnosis of three vessel disease.

Conclusion: Our interim analysis indicates that positive GSF score, but not Canadian frailty or GRACE scores provides independent prediction of short term clinical outcomes in ACS patients. Further data collection and analyses are being performed and we will present final study results of 800 patients (powered for primary endpoint) at ESC Congress in August/September 2013 at Amsterdam.

P3084 | BEDSIDE
Epicardial adipose tissue thickness is independently related to the coronary atherosclerotic burden determined by SYNTAX and Gensini score

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Purpose: Epicardial adipose tissue (EAT), is a specialized visceral fat depot localized between myocardium and visceral pericardium. It acts as an endocrine and paracrine organ and it has been shown to be associated with the presence, severity and extent of atherosclerotic coronary artery disease (CAD). We aimed to search if EAT thickness is associated with Gensini score and Syntax score which is a relatively new system to score complexity of coronary artery disease.
Methods: We included 200 consecutive patients who were admitted with stable angina pectoris or acute coronary syndrome, and decided to undergo coronary angiography. Patients were divided into three groups, namely; normal coronary arteries, minimal CAD (at least one coronary atherosclerotic lesion with <50% stenosis) and significant CAD (at least one coronary atherosclerotic lesion with >50% stenosis). Epicardial adipose tissue thickness was evaluated by transthoracic echocardiography. Coronary angiography was performed; Gensini score and Syntax score were calculated.
Results: Mean EAT was 4.3±0.9, 5.2±1.5 and 7.5±1.9 mm in the patients with normal coronary arteries, minimal CAD and significant CAD groups respectively (p<0.001). With increasing EAT thickness Gensini score and Syntax score increase (for EAT thickness <5 mm, 5-7 mm, >7 mm; mean Gensini scores were 4.1±5.5, 19.8±15.6 and 64.9±32.4 and mean Syntax scores were 4.7±5.9, 16.6±8.5 and 31.7±8.7 respectively; both p<0.001). Multivariate analysis and ROC analysis revealed that EAT can be used as an independent predictor of significant CAD. Cut-off EAT value to predict significant CAD was identified as 5.8 mm (ROC analysis 0.875; p<0.001, 95% CI:0.825- 0.926). Sensitivity and specificity of EAT cut-off 5.8 to predict significant CAD were 77% and 83% respectively.
Conclusion: EAT thickness is significantly associated with more severe, extensive and complex CAD and it can be used as a reliable predictor of significant CAD. Determination of EAT by echocardiography is a cheap and practical method to identify patients who would need more agressive risk reduction.

P3085 | BEDSIDE
Estimation of glomerular filtration rate in acute coronary syndromes: comparison between cockcroft-gault, modification of diet in renal disease and chronic kidney disease epidemiology collaboration

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Purpose: Chronic Kidney Disease (CKD) is a frequent morbidity in patients admitted for acute coronary syndrome (ACS). Several equations to correctly identify patients with CKD through glomerular filtration rate (GFR) exist, but it is still not consensual which one is the most appropriate in the setting on ACS. We aimed to compare which of the 3 more commonly used formulas - Cockcroft-Gault [CG]; Modification of Diet in Renal Disease [MDRD] and Chronic Kidney Disease Epidemiology Collaboration [CKD-EPI] – is more effective in predicting a worse outcome at 1-year follow up.
Methods: Retrospective study of 560 consecutive patients [age 66.01±12.96; 65.9% men; 0.18% black; 30.7% diabetics; 69.1% hypertensive] admitted to our coronary intensive care unit of a tertiary hospital for ACS between October 2009 and October 2011. GFR estimates from CG, MDRD and CKD-EPI were compared in terms of prediction of mortality and of a composite primary endpoint (re-infarction, stroke and mortality) at 1-year follow up.
Results: Prevalence of GFR <60 ml/min/1.73m^2 was 43.1% using CG, 46.1% with MDRD and 41.8% with CKD-EPI. All 3 formulas showed good results in predicting 1-year composite primary endpoint with CG proving to be the best formula by ROC curve analysis [AUC (CG): 0.747 vs AUC (MDRD): 0.711 vs AUC (CKD-EPI): 0.725]. All formulas were valuable in predicting 1-year total mortality with CG showing the best results. [AUC (CG): 0.78 vs AUC (MDRD): 0.735 vs AUC (CKD-EPI): 0.751].
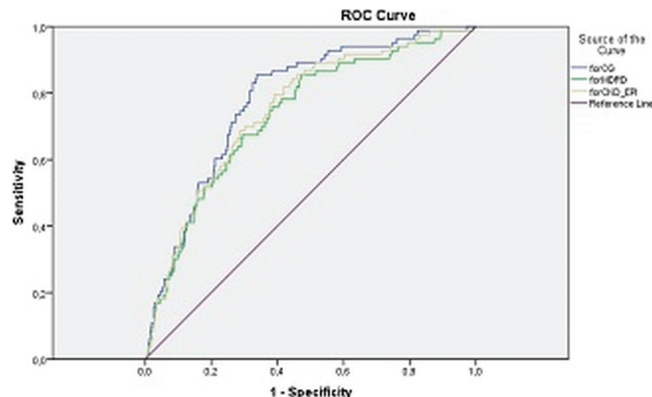
ROC curve of total mortality

Conclusions: In our, almost exclusive, white population all formulas proved value in predicting adverse outcomes at 1-year follow up. The CG formula was significantly more accurate than MDRD and CKD-EPI.

P3086 | BEDSIDE
Differing attitudes in anticoagulation therapy in atrial fibrillation patients with and without coronary artery disease: results from the registry of atrial fibrillation to investigate new guidelines

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Purpose: Patients with atrial fibrillation (AF) and concomitant coronary artery disease (CAD) represent a challenging therapeutic problem since combinations of antithrombotic medications may be needed. In this report, we examined the characteristics and the antithrombotic therapy of patients with AF with or without CAD.
Methods: The Registry of Atrial Fibrillation To Investigate New Guidelines (RAFTING) is a countrywide prospective observational study of the Hellenic Society of Cardiology. We enrolled 1127 consecutive patients with a diagnosis of AF during their admission for any reason in the Emergency Departments of 31 hospitals trying to capture a representative picture of the characteristics and treatment of AF patients in Greece. After excluding patients with newly diagnosed AF, we identified 195 patients with AF and CAD (group A) and 533 patients with AF without CAD (group B).
Results: Patients of group A vs group B were older (74±8 vs 70±12 years; p<0.001), with higher calculated CHADS2 score (2.5±1.2 vs 1.9±1.3; p<0.001) and had less often paroxysmal AF (34% vs 50%; p<0.001). Overall, the antithrombotic strategy in group A was antiplatelet-only therapy in 42%, vitamin-K antagonist (VKA)-only therapy in 41% and combination of antiplatelet plus VKA in 17% of patients, while in group B the respective rates were 27%, 53% and 1% (p<0.001). Of those patients with antiplatelet-only strategy, 18% in group A and 3% in group B received dual antiplatelet therapy (p<0.001). In patients with a history of previous stenting, combination therapy with antiplatelet plus VKA was used in 23%. Patients with a CHADS2 score ≥2 were treated without VKA in 41% of group A and 35% of group B (p<0.01). In group B, 31% of patients with a CHADS2 score=0 were treated with VKA. At 6 months follow-up, 11 major bleeding episodes were reported (only 1 with combination therapy).
Conclusion: In this representative countrywide registry of AF we found that combination of antithrombotics is kept at low rates especially in patients without CAD resulting in low bleeding at follow-up. However, it seems that patients without CAD at low embolic risk as assessed by CHADS2 score are rather overtreated with VKA while at the same time patients with CAD at high embolic risk are undertreated. At national level, more efforts to base anticoagulation therapeutic decisions by estimating embolic risk objectively with the use of appropriate scoring systems are needed.

P3087 | SPOTLIGHT 2013
Glycosilated haemoglobin but not resting glycaemia is independently associated with coronary artery disease in patients without diabetes mellitus

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Coronary artery disease (CAD) is the leading cause of mortality in developed