RESULTS Patients’ clinical summary, timing of LA decompression, procedural data, and outcomes are summarized in Table 1. Within Jan 2012 and Dec 2012, there were 6 cases who received Inoue BAS for LA decompression during ECMO support. The average age was 43.5 (range of age 22-55), and the average body weight was 72.8 kilogram (range of body weight 58-101). Four of them (66%) suffered from cardiogenic shock due to ischemic cardiomyopathy, while the other 2 patients were victims of dilated cardiomyopathy and refractory ventricular arrhythmia.

All reported patient received ECMO on the admission day. There LV function was evaluated with echocardiography which showed LV ejection fraction (LVEF) was within 10 to 22%. Inoue BAS was performed in 1 week with average 3.3 days. The pulmonary edema all significantly resolved in 5 days (Figure 1). Patient 1 and patient 3 successfully weaned from mechanical ventilator and received left ventricular assisted device (LVAD) in place of ECMO. Both underwent heart transplantation and recovered their daily performance finally. Patient 6 restored his LV function partially after anti-arrhythmic agent. He weaned from ECMO and mechanical ventilator. An implantable cardioverter defibrillator was placed. Patient 4 also recovered his LV function partially and weaned from ECMO. However, he depended on ventilator due to impaired consciousness. Patient 2 and patient 5 were dead of severe sepsis. The procedure success rate was 100% while the survival rate was 66%.

The average procedure time of Inoue BAS was 49.6 minutes. Patient 6 who were the youngest and lightest underwent longest procedure time (85 minutes) for more difficulty in localizing transseptal puncture point. Most of patients received Inoue balloon size of 24mm. However, patient 5 who was the heaviest received a larger size of Inoue balloon (27mm). All the procedures were performed without complications.

CONCLUSION In patients with persistent pulmonary edema after ECMO, effective LA decompression can be achieved by Inoue balloon catheter atrial septostomy. Myocardial dysfunction on ECMO, decompression of the left atrium using the Inoue balloon atrial septostomy represents a reasonable alternative procedure of BAS.

TCTAP A-089
Correlation of Magnitude of ST-Segment Depression in Leads V1 to V4 in Acute Inferior Myocardial Infarction with Angiographic Severity of Coronary Artery Disease
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BACKGROUND Inferior wall acute myocardial infarction accounts for 40 to 50% of all AMI. The mortality and morbidity of AMI inferior largely depends on the site of coronary artery lesion. Early identification of left coronary system lesion has got immense impact on patient’s outcome. We know that patients of acute inferior myocardial infarction with ST depression in lateral leads often have greater incidence of triple vessel disease and proximal RCA lesion. But in case of patients of acute inferior myocardial infarction with ST depression in leads V1 to V4, it is subject of determination whether it is associated with single, double or triples vessel disease. So in the aforementioned context, magnitude of sum of ST depression play a paramount importance in assessing number of vessels involved. The greater the sum of ST depression in these leads, the more is the probability of concomitant double or even triple vessel disease. So ECG can predict severity of coronary artery stenosis and can guide to take decision for early angiography and subsequent revascularization.

METHODS This study was conducted in the National Institute of Cardiovascular Diseases, Dhaka, Bangladesh during 2011. 90 consecutive patients who had acute inferior myocardial infarction presented within 12 hours of onset of chest pain were selected for the study. Precordial ST segment depression was defined as ST segment
depression of 1 mm in at least two contiguous leads out of four pre-
cordial leads from V1 to V4 and was included into the study. All the
patients had undergone coronary angiography within the index
admission. All data were analyzed through SPSS software system.
Pearsons correlation coefficient was used for correlation study (for
t value) and level of significance was carried out by Pearsons corre-
lation T test (for p value).
RESULTS 93.3% and 92.2% had lead V3 and V2 ST depression. Mean
ST segment depression in V2 was highest (2.46 ± 1.67 mm). Mean sum
of ST segment depression (from V1 to V4) was 5.77 ± 3.97 mm. Double &
triple vessel involvement was 38.9% each. RCA was 81.1% with
significant LAD involvement (63.3%). LCX was 50%. Severity of cor-
onary artery disease was assessed by Gensini & Reardon score, mean
value of which was 30.2 +/- 917.49 and 5.96 +/- 2.48. Thereafter, a
correlation was depicted by sumamation values of ST depression
in mm with that of Gensini & Reardon score and turned out to be
positive as evidence by the r value. For Gensini score it was 0.61 and
for Raerdon score was 0.52.
CONCLUSION All who had LAD lesion, had sum of ST depression
> 4 mm except three. Henceforth it could be mentioned that increased
value of sum of ST segment depression in leads V1 to V4 during acute
inferior myocardial infarction is associated with more frequent &
developed coronary artery disease. Thus the study reveals high severty of ST segment depression in leads V1 to V4 is directly propor-
tional to the extent of coronary artery disease as reflected by the
r value of Gensini score and Reardon score.

TCTAP A-090
Extra Vascular Access Closure in Anti-Coagulated Patients Under Going Prcutaneous Intervention
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BACKGROUND Vascular access site complications, particularly
bleeding complication, in percutaneous endovascular interventions is
a relentless problem. Several access closure devices have been
developed over the years. Closure devices can be broadly classified into extrTCTAP A-vascular and intra-vascular types. All of them have their own inherent advan-
tages and dis-advantages.
An ideal vascular closure device should be easy to deploy, relatively safe and effective with minimal complications. It should also be a
versatile device and universally applicable to all types of patients.
Despite several accesses closure devices that are available access site complications are a common place.
Radial access has become popularized as an alternate with minimal complications. However radial access is not without problems and has limitation as to the choice of devices that can be used due to access vessel size limitation.
METHODS Increasingly complex percutaneous vascular in-
terventions have been attempted with high risk co-morbidities such
as diabetic vasculopathy and PAD with growing diversity of per-
cutaneous interventional devices.
To minimize access site complications particularly bleeding at the same time not loose large vessel access capability we adapted femoral and brachial access for interventions followed by immediate access closure using MYNX extrTCTAP A-vascular closure device.
The protocol involved adjunctive therapies to extra-vascular closure
when indicated in high risk bleeding patients.
Anti-coagulation was carried out in accordance with standard
therapy guidelines.
RESULTS RENU-CA research Institute MYNX experience in anti-
couagulated patients undergoing PCI:
414 cases from 2010 - 2014.
Anti-coagulated - ACT 250 - 350 secs.
Brachial access - 9pts.
Venous access closure - 18pts.
Peripheral arterial disease pts > 200.
Procedural success > 98%.
Device failure - 18.
Break through bleeding - 3.3%.
Access sheaths - 6FT, 7FT, 8FT.
Single perclose suture device / MYNX combination for successful
closure of 14-18 Fr access sheaths after Impella device and AAA
percutaneous stent grafting - 4pts.
CONCLUSION Extra vascular access closure is safe.
It can be very effective when used with proper technique.
Complications are minimal and are usually minor.
No risk for threatened limb loss or urgent surgical exploration.
Endothelial integrity not damaged.
Can be used to close venous access in anti-coagulated patients.
Brachial access with MYNX closure can be an alternate to Radial access with comparable complication rates and costs.
Brachial access allows for more choices for device selection compared to radial access.

TCTAP A-091
Contrast-Induced Nephropathy
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BACKGROUND The most commonly accepted definition of contrast-
induced nephropathy is an increase in serum creatinine concentration by >0.5 mg/dL (44 umol/L), or a 25% increase above baseline in the
resulting 48-72 hours postinfusion of intravenous or intra-arterial contrast media.
— A new definition of contrast nephropathy in patients undergoing
percutaneous coronary intervention was recently proposed by Harjai, et al. This tripartite definition classifies contrast nephropathy as:
— grade 0 (serum creatinine increase <25%above baseline and <0.5
mg/dL above baseline).
— grade 1 (serum creatinine increase >/=25%above baseline and
>0.5 mg/dL above baseline).
— grade 2 (serum creatinine increase >/=0.5 mg/dL above baseline).
This classification is prognostic of long-term outcomes of patients
after percutaneous coronary intervention. Patients with grade 2 nephropathy had the worst outcome while those with grade 0 nephropathy had the best outcome on long-term follow-up.

METHODS

RESULTS CIN is normally a transient process, with renal functions
reverting to normal within 7-14 days of contrast administration.
Less than one-third patients develop some degree of residual renal
impairment.
Diagnosis is required in less than 1% of patients, with a slightly higher incidence in patients with underlying renal impairment (3.1%) and in those undergoing primary PCI for myocardial infarction (MI) (3%). However, in patients with diabetes and severe renal failure, the rate of dialysis can be as high as 12%.
Of the patients who need dialysis, 18% end up on permanent dial-
ysis therapy. However, many of these patients will have had advanced renal insufficiency and concomitant diabetic nephropathy and will
have been destined for dialysis regardless of the episode of CIN.
CONCLUSION Of course, limiting the total contrast volume aids
greatly in reducing the incidence of contrast nephropathy.
Good Hydration for the patient before intervention is mandatory in
reducing the incidence of contrast nephropathy.
Risk scoring before intervention and follow up after intervention can
also helping you in reducing the incidence of contrast nephropathy.

TCTAP A-092
Relationship Between Door-to-Balloon Time and Short- or Long-Term Outcome in Patients with ST-T Segment Elevation Myocardial Infarction
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BACKGROUND Whether a delayed door-to-balloon (DTB) time was
associated with a higher mortality in patients with ST-segment
elevation myocardial infarction (STEMI) undergoing percutaneous
coronary intervention (PCI) still remains controversial.
METHODS We investigated the relationship between DTB time and long
term outcomes in a multicenter, retrospective observational study. A total of 921 STEMI patients underwent primary PCI between January 2007 and
December 2012. Out of them, 838 STEMI patients were revealed accurate
DTB time. Patients were classified into the two categories depending on the