prognosis of complete revascularization (CR) versus incomplete revascularization (IR) on patients with multivessel coronary artery disease (CAD) who underwent percutaneous coronary intervention (PCI) or coronary artery bypass graft (CABG).

**METHODS** From May 2003 to December 2013, a total of 9,582 patients were analyzed who underwent PCI or CABG for multivessel disease. Major adverse cardiac event (MACE) including all-cause death, myocardial infarction and repeat revascularization was compared between CR and IR group.

**RESULTS** CR was achieved in 4,423 patients (46.2%); IR was more common after PCI than CABG (62.1% vs. 39.6%, p < 0.001) and IR group presented with more myocardial infarction than CR group (30.4% vs. 24.6%, p < 0.001). During a 10-year follow-up, MACE occurred more in IR than CR group (44.4% vs. 36.9%, P = 0.001). Relative to IR, CR was associated with lower long-term mortality (adjusted hazard ratio [HR]: 0.876, 95% confidence interval [CI]: 0.782 to 0.982, p = 0.023), myocardial infarction (HR: 0.680, 95% CI: 0.524 to 0.882, p = 0.004), and repeat revascularization (HR: 0.777, 95% CI: 0.682 to 0.887, p < 0.001). And the survival free from MACE was most benefited in completely revascularized CABG patients (HR: 0.575, 95% CI: 0.509 to 0.648, p = 0.005).

**CONCLUSIONS** In a 10-year follow-up, the achievement of CR in multivessel CAD was associated with reduced MACE rate, irrespective of revascularization strategy in the real world.

**CATEGORIES CORONARY:** Angioplasty Overview and Outcomes

**KEYWORDS** Complete coronary revascularization, Multivessel disease

**TCT-398** Restenosis of Left Main – Is One Shot All You’ve Got?

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**BACKGROUND** Percutaneous management of ULM disease has gained guideline acceptance for those with low-to moderate SYNTAX scores. There are few data to guide best management of restenosis in this setting. We sought to evaluate the management and outcomes of restenosis after unprotected left main (ULM) stenting.

**METHODS** From a total sample of all patients presenting for angiography between January 2009 and December 2014 with ULM lesion > 50% (n = 1,362), we identified those with angiographically significant ULM in lesion restenosis (n = 42). The primary end-point was long-term rate of major adverse cardiac events (MACE) – that is death, myocardial infarction (MI) or clinically driven target lesion revascularization (TLR).

**RESULTS** Significant ULM lesion restenosis was identified in 43 patients (3%). The clinical indication for angiography was stable angina in 33 (78%), non-ST-elevation MI in 8 (18%), ST-elevation MI in 1 (2%) and cardiac arrest in 1 (2%). The initial stenting strategy was a simple one-stent approach in 24 (56%) and a complex 2-stent technique in 19 (44%). Details of the initial stent utilized were available in 37 – drug eluting stent 29 (78 %), bare metal stent (BMS) 5 (14%) and bioresorbable vascular scaffolds 3 (8%). Restenosis was treated percutaneously in 26 patients (60%) - additional DES in 22 (84%); balloon angioplasty in 3 (12%); thromboaspiration in 1 (4%). The remaining 40% were managed surgically. Table 1 shows clinical details by treatment strategy. For those undergoing repeat PCI a simple 1-stent strategy was employed in 19 (86%). In-hospital MACE rates was 7% with individual components of death 4.7% (2) and MI 2.3% (1). After 30+19 months follow-up cumulative MACE rate was 23.3% comprising of death in 5 (12%), MI in 2 (4.7%) and re-TLR in 1 (2.3%). There was no reported MACE in the surgically managed group.

**CONCLUSIONS** Restenosis after ULM stenting presents with a stable clinical course and can be percutaneously managed with a simple one-stent strategy in the majority of cases with low repeat TLR rates. The higher MACE rates for those managed percutaneously may be explained by operator bias to treat older, more unstable patients with repeat PCI.

**CATEGORIES CORONARY:** Complex and Higher Risk Procedures for Indicated Patients (CHIP)

**KEYWORDS** Left main coronary artery disease, Restenosis