

We sought to determine the prevalence, predictors and prognostic value of BC in patients (P) admitted with ACS.

Methods: Retrospective study including 1345 P with ACS consecutively admitted to a coronary care unit over 3 years and during a minimal 6 months follow-up. BC were defined according to TIMI or GUSTO classification systems. BC classified as minimal or mild were excluded.

Results: During hospitalization, 53 (3.9%) P developed BC and 1.7% had severe BC. P situation BC were older (70 ± 12 vs 64 ± 13 y; $p=0.002$) and more often had chronic renal failure (15.1% vs 4.1%; $p=0.002$). At admission, they had more often signs of heart failure (HF) (49.1% vs 20.4%; $p<0.001$). They had higher mean levels of creatinine ($p<0.001$), cystatin C ($p=0.023$), type B natriuretic peptide ($p<0.001$) and red blood cell distribution width (RDW) ($p=0.029$), and lower mean levels of glomerular filtration rate (GFR), estimated either by MDRD equation ($p<0.001$) or Cockcroft-Gault equation ($p<0.001$). The echocardiographic evaluation showed that they had more often moderate to severe left ventricular systolic dysfunction (46.2% vs 31.9%; $p=0.029$). They were less likely to undergo invasive stratification (7.6% vs 1.6%; $p<0.001$), and when done, they had more often left main (22.6% vs 10.3%; $p=0.028$) and multivessel disease (66.0% vs 44.6%; $p=0.002$). After multivariate analysis, HF at admission, lower GFR and higher RDW persisted as independent predictors of BC. BC were an independent predictor of mortality (OR 4.20; CI 95%: 2.6-6.2; $p<0.001$) and in-hospital MACE (OR 6.8; CI 95%: 1.3-3.2; $p<0.001$), but this trend didn't persisted in follow-up.

Conclusion: BC predict a poor in-hospital outcome. Ischemic risk stratification plays a central role in optimal treatment approach and should be complemented by bleeding risk assessment. In this study, the presence at admission of HF, renal dysfunction and high RDW values were independent predictors of BC.

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Impact of invasive strategy in elderly patients referred for acute coronary syndrome

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Background: Limited data are available in elderly patients admitted for acute coronary syndromes (ACS). The purpose of this study is to assess the beneficial impact of aggressive treatment strategy (i.e. coronary angiogram and revascularization) on outcome in elderly patients.

Method: Among 1702 patients admitted for ACS, 294 patients were ≥ 80 years old. ACS was defined as chest pain associated with either troponin rise or new change in ST segment or T wave. Patients with STEMI were excluded and 235 patients (85 \pm 3 years old, 125 men) were analyzed. We compared outcome (death and emergency readmission) according to treatment strategy (conservative or invasive)

Results: Coronary angiography was performed in 146 patients while 88 received medical treatment alone. Patients with angiography performed were younger (84.5 \pm 3.2 years vs. 85.6 \pm 3.9 years) but had similar event risk (GRACE score 174 \pm 26 vs. 179 \pm 33). During follow up (median=498 days), one year mortality and emergency readmission was similar regardless the decision to perform angiogram (41.2% vs. 43.6%, $p=0.7$) but in hospital stay was longer when angiogram was performed (4.1 \pm 3.7 vs. 2.9 \pm 2.8, $p=0.01$). Among the 146 patients who underwent angiography, revascularization was performed in 98. Age did not influence revascularization but Grace score did (177 \pm 26 vs. 167 \pm 30). Importantly, only patients with Left main (LM) or proximal LAD disease benefited from revascularization (1-year free event survival 26% vs. 79%, $p=0.0003$) whereas patients without did not (39% vs. 35%, $p=0.7$). Kaplan Meier analysis of outcome during follow up confirmed that patients with non revascularized LM or proximal LAD disease had worse outcome (LogRank $p=0.009$)

Conclusion: Invasive management of ACS in elderly patients improves survival in patients with LM or proximal LAD disease. In other patients, it only prolongs in-hospital stay. Upstream stratification may be useful to identify patients with suspected LM or proximal LAD disease.

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Acute coronary syndrome and diabetes mellitus in elderly patients

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Coronary heart disease is the first cause of morbidity and mortality in diabetic patients. Its incidence in elderly patients increases with the increase of their life expectancy. The aim of our study was to evaluate the characteristics and the management of elderly patients with diabetes and compared this with non-diabetics patients.

This is a comparative retrospective study of 204 elderly patients (>75 years) admitted for ACS in Haguena Hospital center in France, between August 2012 and August 2013. We compared 63 elderly patients diabetics (GI), with 141 elderly patients non-diabetic (GII)

The mode age: 80years (GI), 82years (GII). A male predominance noted in the both groups. More risk factors in (GI): hypertension ($p=0.002$), dyslipidemia ($p=0.034$), while (GII) is more smoker ($p=0.003$). More comorbidities for (GI), especially high frequency of renal failure ($p<0.001$). Predominance of atypical pain in both groups. NSTEMI was predominant in the both groups. At coronary angiography, three-vessel involvement was more frequent in (GI). Percutaneous coronary intervention (PCI) is less used in the GI (62.7%) to GII (69.5%). Hospital complications were higher in diabetics particularly: renal failure ($p=0.04$). Evolution at 6 and 12 months ago shows a more predominance of complications in diabetics. The quality of life of nondiabetic is better than in diabetics. On the other hand, the quality of life of the diabetics after PCI was better to conventional therapy. Elderly diabetic patients are very high cardiovascular risk, characterized by the severity of coronary artery disease. Diabetics are treated less aggressively than non-diabetics yet that diabetics quality of life improves better with angioplasty in comparison with the conventional treatment.

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Quality of life and complication after acute coronary syndrome in elderly patients

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Acute coronary syndrome in the elderly patients is a particular clinical entity characterized by increased incidence. Medical advances and improvement of the conditions of life acquires of the elderly person the progression of their autonomy. Our aim is to evaluate the quality of life of elderly patients after ACS treated by angioplasty.

We had collected 141 elderly patients (>75 ans) (mean age: 80.6 \pm 4.03 years old) admitted for NSTEMI in Haguena hospital center in France, between August 2012 and August 2013. 58.2% had percutaneous coronary intervention (PCI), 34% medical treatment and 7.8% CABG. In the acute phase after PCI: renal failure 11% (vs 6.3% after medical treatment), heart failure 7.3% (vs 6.3%), recurrence infarction 6.1% (vs: 0%). Mortality of 2.4% (vs: 0%).

At 6 months after PCI: renal failure 3.8% (vs: 0%), recurrent infarction 7.5% (vs 4.2%) and heart failure 6.3% (vs 8.3%). Mortality of 1.4% (vs: 0%). The quality of life has improved in 45% after PCI, versus 12.5% after medical treatment.

At 1 year after PCI: mortality 1.3% and recurrent infarction 1.3%. The quality of life has improved in 53.2% versus 12.5% after medical treatment. While a stationary quality of life is noted in 72.9% after medical treatment.

Angioplasty in elderly patients improves the quality of life, especially of physical health, but with some cases of complications. While medical treatment that maintained a steady state of quality of life with fewer complications.