regimens except for Nicorandil. There was not much hemodynamic alteration with 200µg Nitroglycerin. The incidence of side effects of Nitroglycerin such as headache was also rare. In general, the combination of Nitroglycerin and Calcium Channel Blocker was better than either Nitroglycerin or Nicorandil in preventing the spasm of radial artery. Verapamil 2.5mg used in combination with Nitroglycerin 200µg is better in preventing radial artery spasm than combination of Diluzazen 5mg and Nitroglycerin 200µg. Rashesh and vasovagal phenomenon was seen to occur more commonly with Diluzazen.

**Conclusion:** The occurrence of radial artery spasm during transradial coronary angiography is prevented by intraarterial injection of Nitroglycerin with or without calcium channel blocker. The best regimen to prevent spasm of radial artery in an ideal patient is the combination of Gemfibrozil, Mannitol and Calcium channel with 2.5mg of Verapamil. Nicorandil was less effective in preventing radial artery spasm.

**TCTAP A-121**

Transradial Versus Transfemoral Intervention in ST-segment Elevation Myocardial Infarction Patients Undergoing Primary Percutaneous Coronary Intervention with Drug-eluting Stents

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**Background:** Transradial intervention (TRI) is drastically increasing in every intervention society around the world because of the lower incidence of major bleeding and vascular complications compared with transfemoral intervention (TFI). However, there have been limited data regarding clinical outcomes of TRI versus TFI in ST elevation myocardial infarction (STEMI) patients in Asian population.

**Methods:** A total of 689 consecutive STEMI pts from nine major hospitals were enrolled from Jan to Dec 2009. Cumulative major clinical outcomes up to 12 months were compared between TRI (n=220, 31.9%) and TFI group (n=469, 28.1%).

**Results:** Baseline characteristics showed that TRI group had more smokers and a higher incidence of hypertension, diabetes mellitus and previous cerebrovascular accidents whereas TFI group had a higher incidence of multi-vessel disease, left circumflex lesion, type B2 or C lesion and chronic total occlusion. TRI group had a lower incidence of major and minor hemorrhage during admission. Clinical outcomes up to 12 months showed that the incidence of recurrent myocardial infarction, target lesion revascularization (TLR) and target vessel revascularization (TVR) were lower in the TRI group. Propensity score matched analysis showed that TRI was an independent predictor of reducing TVR (OR: 0.38, 95% CI: 0.18-0.75, p Value =0.019), MACE (OR: 0.37, 95% CI: 0.13-0.86, p Value =0.022), and MACCE (OR: 0.33, 95% CI: 0.14-0.76, p Value =0.010) at 12 months.

**Conclusion:** In our study, TRI in STEMI pts undergoing primary PCI with DES was associated with lower 12-months TVR, MACE and MACCE. We suggest that TRI may play an important role in improving mid-term major clinical outcomes of STEMI pts undergoing PCI with DESs.

**TCTAP A-122**

The Use of Sheathless Eaucath to Overcome Radial Artery Spasm and Perforation

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**Background:** Transradial access (TRA) for percutaneous coronary intervention and diagnostic coronary angiography has become an emerging trend in the routine practice in most catheterization laboratory as it reduces the incidence of major access site complications such as bleeding and haematoma. Radial artery spasm and perforation are the main reasons for converting a procedure to femoral access. We prospectively investigate the use of Sheathless Eaucath (Asahi Intecc, Aichi, Japan) in cases of radial artery spasm and perforation.

**Methods:** From Jan 2011 till Oct 2013, all patients with angiographically documented radial artery spasm with or without perforation and failure of conventional 5 or 6 Fr diagnostic or guiding catheters to cross the artery despite of repeated intra-arterial nitroglycerin and/or verapamil were elected to attempt for Sheathless Eaucath. The procedural success, angiography of the forearm post procedure and access site outcomes were evaluated.

**Results:** 36 patients, a mean age of 61±9 yrs with 64% male, had significant radial artery spasm (n=25, 69%) or perforation (n=11, 31%) fulfilled the criteria for the use of Sheathless Eaucath. Procedural indications are stable angina in 18%, unstable angina in 3%, non-ST elevation myocardial infarction (NSTEMI) in 54%, ST-elevation myocardial infarction (STEMI) in 15% and 10% for other diagnostic procedures, 6.5 Fr Sheathless Eaucath was used in 34 patients (94%) and 7.5 Fr was used in the remaining 2 patients (6%). The Sheathless Eaucath was able to overcome the spasm with or without perforation in all cases with all patients achieved a successful procedural outcome. Of the 11 patients who had perforation of the radial artery, 10 patients (91%) had post procedure angiography showed no extravasation of contrast. The remaining one patient who had trivial residual contrast extravasation outside the radial artery was successfully managed with pressure dressing without significant complications. There was no case of haematoma or access site related bleeding issues.

**Conclusion:** The Sheathless Eaucath can be used safely to overcome the radial artery spasm and perforation during transradial coronary intervention or diagnostic procedures.

**TCTAP A-123**

Feasibility of Transradial Coronary Intervention in Patients with Cardiac Arrest Caused by Acute Coronary Syndrome

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**Background:** The latest European Society of Cardiology guidelines for the management of acute myocardial infarction (AMI) in patients with ST-segment elevation recommend transradial coronary intervention (TRI) to reduce the risk of vascular complications. We retrospectively evaluated 20 consecutive patients with AMI who evaluated the feasibility of TRI in patients with AMI complicated by cardiac arrest.

**Methods:** We retrospectively evaluated 20 consecutive patients with AMI who required an extracorporeal membrane oxygenator (ECMO) because of cardiopulmonary arrest resistant to conventional cardiopulmonary resuscitation. Percutaneous access sites and evaluation criteria, including onset-to-ECMO time, door-to-balloon time, and 30-day survival, were investigated.

**Results:** TRI was performed in 13 patients, whereas the other 7 patients underwent transfemoral coronary intervention (TFI). No significant differences in onset-to-admission time (mean ± SD: 26.8 ± 14.6 vs. 17.0 ± 13.3 min), onset-to-ECMO time (41.8 ± 18.8 vs. 39.0 ± 16.6 min), and door-to-balloon time (61.4 ± 19.1 vs. 79.3 ± 18.3 min).