was carried out to adjust for potential confounding between the two groups.

RESULTS 922 patients with ULMCA disease were finally enrolled for the analyses: 465 were treated with DES implantation and 457 with CABG. During the median follow-up of 7.1 years (interquartile range 5.3 to 8.2 years), no difference was found between PCI and CABG in the occurrence of death (adjusted hazard ratio [HR]: 0.791; 95% confidence interval [CI]: 0.516 to 1.212; \( p = 0.282 \)) and the composite end point of cardiac death, MI and stroke (adjusted HR: 0.825; 95% CI: 0.576 to 1.182; \( p = 0.294 \)). Rates of major adverse cardiac and cerebrovascular events were significantly higher in the PCI group (adjusted HR: 1.394; 95% CI: 1.070 to 1.817; \( p = 0.004 \)), in large part because of the significantly higher rate of repeat revascularization (adjusted HR: 2.368; 95% CI: 1.653 to 3.392; \( p < 0.001 \)). PCI was correlated with lower occurrence of stroke (adjusted HR: 0.348; 95% CI: 0.171 to 0.707; \( p = 0.004 \)).

CONCLUSIONS During a median follow-up of 7.1 years (IQR 5.3 to 8.2 years), there was still no difference in rate of death between PCI with DES implantation and CABG in ULMCA lesions in this single-center experience. CABG group was observed to have significantly lower rates of repeat revascularization but higher stroke rates compared with PCI.

GW26-e1447
Recanalization of coronary chronic total occlusion and its effects on myocardial perfusion and long term outcome
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OBJECTIVES The recanalization of the coronary chronic total occlusion (CTO) is also not equal to the improved left ventricular function. The present study will analyze which factors are contributing to successful recanalization, the long term clinical outcomes and the effects on myocardial salvage.

METHODS The patients who underwent coronary angiography (CAG) from 2008 to 2013 were consecutively enrolled. The patients were divided into 3 groups, the total occlusion and stenosis groups (group 1); total occlusion myocardial perfusion group (group 2); CTO PCI group (group 3). In the group 1 comparison was made between total occlusion and high grade stenosis and the patients were followed for the major adverse cardiovascular events. In the group 2 patients were divided into total occlusion and stenosis. The SPECT summed rest score, CAG indices (Syntax score, total MPG and MPG×Area), echocardiography indices (LVED and EF) were calculated. In the group 3, 559 CTO patients were divided into successful and unsuccessful recanalization. The MPG, Bridge Point, Retrogade MPG, LVED and EF were calculated.

RESULTS In the group 1, 253 total occlusion and 629 stenosis were included. No difference in clinical characters was found between total occlusion and stenosis except Syntax score. The MACE was significantly higher in total occlusion than in stenosis (\( p < 0.05 \)). No difference in MACE among PCI, CABG and medicine treatments. In the group 2 there were 111 patients who underwent SPECt and CAG, of them 41 had total occlusion and 70 had stenosis. The total occlusion had significantly larger SRS, higher SYNTAX score, reduced total MPG and MPG×Area, enlarged LVED and reduced EF (\( p < 0.05 \)). Stepwise multivariate analysis showed that the SRS were independently correlated with EF, total occlusion and sex. In the group 3, 559 CTO attempted PCI. The success rate was 67%. Stepwise multivariate analysis showed age, unfavorite CTO and higher J-score predicted unsuccessful recanalization. After successful PCI there were 175 MPG2-3 and 99 MPG0-1. Low MPG accounted for 36% and had low Bridge Point, low Retrogade MPG and increased LVED (\( p < 0.05 \)). There were 190 Bridge Point 0-1 and 369 Bridge Point 2-3. Low Bridge Point accounted for 34%. After FSmacth we found that low Bridge Point were correlated with complex CTO, high J-score, Retrogade MPG, low EF and enlarged LVED (\( p < 0.05 \)).

CONCLUSIONS Medication and CABG have similar clinical outcome irrespective of CTO or stenosis. But CTO PCI may have poor clinical outcome in comparison with stenosis. In CTO PCI the artery integrity damage is more than stenosis. The myocardial perfusion and left ventricular function are poor in the reference group. In CTO patients, MPG and Bridge Point, EF and LVED are useful predictors of myocardial recovery after successful recanalization. Age, complex CTO and J-Score are 3 main anatomic factors affecting recanalization. MPG and Bridge Point help predict viability after recanalization.

GW26-e1571
Efficacy and safety of 6-month dual antiplatelet therapy for more than 75 year old patients having BUMA implantation
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OBJECTIVES 12-month dual antiplatelet therapy (DAPT) is recommended after implantation of drug-eluting stents (DESs) in patients with coronary heart disease. BUMA is a new drug-eluting stent with two different functional coating layers, and More than 75 year old patients have more complications like bleeding and gastrointestinal intolerance. The time is not clear for elderly patients with BUMA implantation.

METHODS We reviewed the data of 242 consecutive more than 75 year old patients who had BUMA implantation four years ago and completed 6-month DAPT. They were divided into two groups randomly: 6-month and 12-month DAPT groups. The efficacy (a composite incidence of cardiac death, myocardial infarction and target vessel revascularization) and safety (incidences of bleeding, gastrointestinal trouble and drug discontinuation) were compared with two groups.

RESULTS 242 patients included in the analysis, 118 were 6-month DAPT group, 124 were 12-month DAPT group. The mean follow-up duration was 24±1.8 months after BUMA implantation. The age, history of diabetes, hypertension and stroke, BMI, SBP, DBP, high-density lipoprotein-cholesterol (HDL-C), triglycerides (TG), fasting blood glucose (FBG), estimated glomerular filtration rate (eGFR), at baseline did not differ significantly between the two groups. The rates of multi-vessel lesions, prior MI, hemoglobin A1c (HbA1c) and low-density lipoprotein cholesterol were no difference significantly in two groups. There was no significant difference in the overall composite incidence of cardiac death, myocardial infarction and target vessel revascularization in two groups at one years after PCI. The rates of bleeding (especially minor bleeding), gastrointestinal trouble, drug discontinuation and any blood transfusion were markedly lower in the 6-month DAPT group than 12-month DAPT group (2.54% vs 4.84%; 4.24% vs 6.45%; 5.09% vs 8.06%; 0.85% vs 2.42%; \( p < 0.05 \)).

CONCLUSIONS 6-month DAPT may be more preferable to more than 75 year old patients who have undergone BUMA implantation, because of it’s efficacy and safety.