Conclusion: Silent AF in AMI severely impairs long term prognosis, including rehospitalization for heart failure and death. Our large prospective study suggests that silent AF screening should be improved after AMI in order to identify patients at high risk for long term events.

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0209

Long-term clinical impact of pre-hospital morphine use in ST-elevation myocardial infarction patients. FAST-MI 2010 registry

Nicolas Bonnet (1), Alexandre Lafont (1), Lionel Lamhaut (2), Nelson Teixeira (1), Didier Blanchard (1), Francois Schiele (3), Simon Tabassome (4), Nicolas Danchin (1), Etienne Puymirat (1)
(1) CHU Hôpital Européen Georges Pompidou (HEGP) – APHP, Cardiologie, Paris, France – (2) SAMU de Paris, Paris, France – (3) CHU Jean Minjoz, Cardiologie, Besançon, France – (4) CHU Hôpital Saint Antoine-HEGP, Cardiologie, Paris, France

Background: Use of opioids is recommended for pain relief in patients presenting acute myocardial infarction (AMI) but may slow antiplatelet absorption and diminish its effects which can lead to treatment failure in susceptible individuals.

Aim: The aim of this study was to assess the potential clinical impact of pre-hospital morphine use in ST-elevation myocardial infarction (STEMI) patients from a nationwide French registry.

Methods: We assessed in-hospital complications and one-year survival according to pre-hospital morphine use in the French Registry of Acute ST-elevation and non-ST-elevation Myocardial Infarction (FAST-MI) 2010, including 4,169 patients with AMI at the end of 2010 in 213 centres (76% of active centres in France); 2,438 patients had STEMI or left bundle branch block (LBBB), of whom 453 (19%) received morphine during pre-hospital management.

Results: Patients receiving morphine in pre-hospital management were younger, with a higher rate of men, a lower cardiovascular risk profile, and a lower early GRACE score (136±31 vs. 145±35, p<0.001). In-hospital complications (non-fatal re-MI, stroke, stent thrombosis, bleeding and transfusion) and one-year mortality were not significantly different between both strategies after adjustment. Using Cox multivariate analysis, pre-hospital morphine use was not associated with a worse one-year survival (HR=0.69; 95%CI: 0.35 to 1.37, p=0.38). After propensity score matching (417 patients per group), one-year survival was also similar with both strategies.

Conclusion: Pre-hospital morphine use was not associated with an increase of in-hospital complication and one-year mortality; and, could be more used as recommended in the current guidelines.

0272

Unfractionated heparin addition during percutaneous coronary intervention in acute coronary syndrome patients previously treated with enoxaparin: biological impact

Anne Steiner, Sophie Voisin, Simon Mejean, Nicolas Dumonteil, Nicolas Boudou, Didier Carrié, Thibault Lhermusier
CHU Toulouse Rangueil, Cardiologie B, Toulouse, France

Background: The benefit of anticoagulants (AC) to prevent thrombotic complications during percutaneous coronary intervention (PCI) is well established. In acute coronary syndrome (ACS) patients previously treated with enoxaparin, an additional bolus of AC is not recommended if the last injection was realized within 8 h. In this setting, many interventional cardiologists use unfractionated heparin (UFH) at the time of sheath insertion.

Objectives: The aim of our study was to describe local current practices for AC use during PCI in patients already treated with enoxaparin and admitted for ACS and to assess the biological impact of UFH addition at the beginning of the procedure.

Methods: A standardized survey was sent to the interventional cardiologists of the southwest of France to investigate their practice in terms of periprocedural AC use. In 2 centers, ACS patients previously treated with subcutaneous injection of enoxaparin within 8 h and who received intravenous UFH at the time of sheath insertion were prospectively included and their plasma anti-Xa activity was assessed at the sheath insertion and 30 min after UFH bolus. In-hospital bleeding and ischemic events were collected. The adequate therapeutic window was defined by anti Xa activity (range 0.5 to 0.9 IU/mL). Results: Among the 41 interventional cardiologists who replied, a large majority (75,6%) considered the addition of UFH in patients who received enoxaparin within 8 h as a valid option. 47 ACS patients were enrolled. The dose of the bolus of UFH was highly variable from 20 to 90 UI / kg. Anti-Xa activities were above 0.9 IU/mL in 14,9% of patients at the sheath insertion and in 72,3% of patients 30 min after UFH injection. 2 bleeding complications occurred, both in over-coagulated patients. No ischemic events were reported.

Conclusion: The use of UFH in patients who already received enoxaparin may result in over-anticoagulation and lead to bleeding complications.

0190

Dual antiplatelet therapy in stable patients with coronary artery disease in modern practice: prevalence, correlates and impact on prognosis (from the coronor study)

Gilles Lemesle (1), Nicolas Lamblin (1), Thibaud Meurice (2), Olivier Tricot (3), Robert Lallemant (4), Olivier Nugue (4), Maxence Delomez (2), Octave Equine (5), Sylvie Tondeux (6), Christophe Bauters (2)
(1) CHRU Lille, Hôpital Cardiologique, USIC Centre Hémodynamique, Lille, France – (2) Polyclinique du Bois, Lille, France – (3) CH Dunkerque, Cardiologie, Dunkerque, France – (4) CH Boulogne sur Mer, Cardiologie, Boulogne Sur Mer, France – (5) CH Béthune, Béthune, France – (6) Hôpital Léon Schwartzenberg, Le Quesnoy, France

Background: Prevalence and correlates of prolonged dual antiplatelet therapy (DAPT) in stable coronary artery disease (CAD) are unknown. Our aims were to assess the proportion of stable CAD patients under long-term DAPT and the correlates of its prescription, and to analyze its impact on prognosis.

Methods: Between 2010 and 2011, 3691 patients with stable CAD for at least 1 year (median 4 years) were divided in 2 groups according to their antiplatelet therapy regimen at inclusion: patients under DAPT were compared to those under single antiplatelet therapy (SAPT).

Results: Altogether, 868 (24%) patients received DAPT. Factors associated with long-term DAPT were a time interval since the last coronary event <3 years, more multivessel and peripheral disease, prior drug eluting stent implantation and markers for a lower bleeding risk (younger patients, higher body mass index). After propensity score matching, the rate of the composite endpoint (death, myocardial infarction, stroke) at 2 years was similar between patients with or without DAPT: 5.5% versus 5.7% (p=0.9). The rate of bleeding was also similar between groups: 1% versus 0.7%, respectively (p=0.6).

Conclusions: Our study shows that a high proportion of stable CAD patients is under DAPT in modern practice. Several correlates of DAPT were identified. Of note and even so no increase in bleeding was observed, our results do not support the prescription of prolonged DAPT.

0046

Interest in the evaluation of exercise capacity by exercise stress testing in coronary artery disease – example of a series of diabetic women

Ghenia Sadoudi Ep Yaker (1), Mohamed Karim Guerchani (2), Salim Benkhedda (1)
(1) CHUA Mustapha Pacha, Cardiologie A2, Alger, Algérie – (2) Hôpital, Epidémiologie, Alger, Algérie

Background: In exploratory research strategy of coronary disease ranked first exercise stress test (EST). Beyond its positive predictive value represented by the repolarization triggered by stress, it provides additional prognostic and diagnostic information which includes exercise capacity especially

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