34 patients (55%).no patient died during the hospitalization, complications (mainly arrhythmias) occurred in 19.6% of cases.

Conclusion: ACS in the young have specific epidemiological characteristics. Cannabis users represent 22.9% of this population.

0202

Gender impact on revascularization in acute coronary syndrome. The national observational study of diagnostic and interventional cardiac catheterization (ONACI)

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Aims: Gender differences in management of patients with acute coronary syndromes (ACS) have been reported. The aim of this study was to evaluate the impact of gender on myocardial revascularization in patients with ACS from a French nationwide registry (ONACI).

Methods and Results: We analysed data from a nationwide French prospective multicentre registry including 64,932 ACS patients (mean age 65.7±13.3; 27% women, 31% ST-elevation myocardial infarction (STEMI)) recruited in 99 centres between 2004 and 2008. Women were older than men and had higher rates of cardiovascular risk factors. Women were more likely to have normal vessel/non-significant coronary artery disease (<50% stenosis in all epicardial vessels; 8.4% vs. 3.8%, p<0.001) and less likely to have left-main and three vessel disease. After adjustment for age, risk factor, and extent of disease, myocardial revascularization (defined as the use of percutaneous coronary intervention (PCI) or coronary artery bypass grafting) was less frequently used in women than in men (adjusted OR=0.83; 95% CI: 0.78-0.87). For those receiving PCI, In-hospital mortality occurring within 24 hours of intervention was higher in women (3.6% vs. 1.2%; adjusted OR=0.51; 95% IC: 1.22-1.87).

Conclusion: In the present study, women with ACS were likely to have cardiovascular disease risk factors, but were more likely to have normal vessel/non-significant angiographic coronary artery disease. In patients with advanced disease, myocardial revascularization seems to be less used in women compared to men whatever the type of ACS. Further study regarding long-term clinical outcomes according to sex and myocardial revascularization is warranted.

0441

Prognostic impact of tissue protrusion after stenting in patients with acute coronary syndrome: an optical coherence tomography study

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Aim: The real clinical impact of Optical Coherence Tomography (OCT) – defined abnormalities remains unknown. We investigated prognostic impact of tissue protrusion between stent struts after stent implantation in patients with non-ST elevation acute coronary syndromes (NSTEACS).

Methods: Prospective study of consecutive NSTEACS pts (≤72 h) undergoing PCI for an infarct-related artery presenting a single lesion without diffuse disease on the culprit artery. Pts were treated at the operator's discretion. OCT was performed after initial coronary angiogram and at end of angioplasty procedure. Prolapse was defined as projection of tissue (plaque/thrombus) into the lumen between stent struts after implantation. Primary endpoint of procedural complications associated no reflow + PCI-related myocardial infarction (MI) (20% rise in troponin over baseline at 24h). Secondary endpoint was functional result of angioplasty assessed by fractional flow reserve (FFR) measured at end of procedure.

Results: 43 pts were included, mean age 63±11 ans, 90% men. Tissue protrusion was observed in 35(81%), tissue took up a median 8.85% [IQR 6.2-14.2%] of intra-luminal area over a median length of 2.8mm [IQR 1.4-5.2]. Presence of protrusion was not associated with cardiovascular risk factors or pre-treatment with aspirin, thienopyridines, antiGP IIb/IIIa or anticoagulants. Tissue protrusion had no impact on procedural complications or FFR (Table).

Conclusion: Tissue protrusion through struts after stent implantation is frequent on OCT in NSTEACS pts undergoing angioplasty. It occludes on average 10% of in-stent area but does not limit flow or impact on post-procedural complications.

0482

Silent AF in acute myocardial infarction severely impairs long term prognosis

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Background: Silent Atrial Fibrillation (AF) has recently been shown to be common in acute myocardial infarction (AMI) and to dramatically increase in-hospital death. However, the long term prognosis of silent AF in AMI remains unknown.

Methods: From the 1st May 2011 and the 31st January 2013 all the consecutive patients were prospectively analyzed by continuous ECG monitoring (CEM) during the first 48 hours after admission for an AMI. Silent AF was defined as asymptomatic episodes lasting at least 30 sec. Patients discharged alive and with a follow-up at 1 year were included in the present study. Patients who developed silent AF were compared with symptomatic AF and No AF group.

Results: Among the 737 patients included, 96 (13.0%) developed silent AF and 56 (7.6%) developed symptomatic AF during their hospital stay. Compared with the no AF group, patients with silent AF were markedly older 80 (64-84) vs. 61 (53-75) years; p<0.001), more frequently women (42% vs. 30%); p=0.069), and less frequently smoker (24% vs. 37%; p<0.001).GRACE risk score was significantly higher in silent AF group (131(101-148)) than in no AF group (98(75-); p<0.001). They also had a significant left atrial (LA) enlargement with LA surface indexed at 10.1 (8.5-12.6) vs. 9.2 (7.4-10.9)cm²/m²; p<0.001 and LA volume indexed 29.4 (21.0-43.1) vs. 24.1 (18.1-32.9) cm3/m²; p<0.001. At one year follow-up, rehospitalizations for heart failure were more frequent after silent AF (4.2%) or symptomatic AF (8.9%) than in no AF group (1.4%), (p<0.001). One year mortality was dramatically higher in silent AF group (9.4%) and in symptomatic AF group (17.9%) than in no AF group (3.8%) (p<0.001).

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▶

Abstract 0441 – Table

	1st quartile [0-6.2%]	2nd quartile [6.21-8.85%]	3rd quartile [8.86-14.15%]	4th quartile [14.16-31%]	1st quartile [0-6.2%]
No reflow	7.7%	22.2%	0	25%	0.33
Peri-procedural MI	6 (46%)	8 (80%)	6 (60%)	5 (50%)	0.39
FFR post-stenting	0.94±0.03	0.94±0.06	0.93±0.03	0.93±0.04	0.99

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

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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

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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.

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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)

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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

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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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