POSTERS

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separated into access site used, and procedural and clinical outcomes were compared. MACE was reported at 30 days.

Results: 685 patients underwent RA PCI (Radial n = 398 and Femoral n = 287) during the study period. There was a predominance of male patients in the radial group (75.4% Vs 63.4%; p<0.001) and more likely to have left ventricular impairment (32.8% Vs 15.4%; p<0.001). No other difference in baseline demographics was seen between RA PCI groups. Procedural success was identical in both cohorts (98.5 Vs 97.5; p = 0.02) but radial cohort received more drug-eluting stents (91.2 Vs 85.3%; p = 0.03). Guide catheter size in the radial cohort was smaller (6.55F Vs 6.95F, p<0.001), average burst size was similar. The femoral group underwent more left main PCI (14.2% Vs 21.8%, p = 0.01) and additional imaging (23.2% Vs 32.9%; p = 0.03). The procedural time (76.3 Vs 92.6mins, p<0.001) and time to first balloon inflation (39 Vs 54mins, p<0.001) were significantly lower in the radial cohort, as was mean length of stay (1.43 Vs 2.93 days, p=0.008). Bleeding and vascular access complications were similar between the two groups as was 30 day MACE (Radial 6.45% Vs Femoral 4.08%; p = 0.15).

Conclusions: This is the largest comparison to date of radial versus femoral access revascularization. Our data demonstrate that radial RA PCI can be performed safely, with smaller guide catheters and similar procedural success. Procedural time and time to first balloon inflation was significantly less in the radial cohort, whereas 30 day MACE rates and access-associated complications were similar between both groups. Our results show that radial access is safe, effective and perhaps more efficient method for performing RA.

TCT-296

Assessment the performance value of CRUSADE and MEHRAN bleeding risk scores with the observed bleeding events among ACS Tunisian patients.

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Background: Bleeding is a major complication in patients treated for acute coronary syndrome (ACS). It is associated with increased risk of mortality. Consequently, the benefit of such therapies should be balanced against the potential risk of hemorrhagic complications. CRUSADE and more recently MEHRAN models provide two risk scores that predict the likelihood of major bleeding in patients hospitalized with ACS. The aim of this study: was to evaluate the performance of both CRUSADE and MEHRAN risk scores to predict in-hospital major bleeding in a contemporary cohort of patients hospitalized for ACS in One center in Tunisia.

Methods: The study subjects were 278 consecutive patients admitted to our center between January 2010 and August 2011 with ACS. For each patient, we calculated both the CRUSADE and MEHRAN risk score and evaluated its discrimination by the C statistic.

Results: By CRUSADE and MEHRAN risk scores, our patients were classified as high or very high risk of major bleeding in 24.8%, 45.7% of cases, respectively. The overall incidence of in-hospital bleeding events and major bleeding (BARC major definition: BARC 3, BARC 4 and BARC 5) was 12.6%, 4.4%, respectively. The major bleeding rate increased with the CRUSADE risk category: very low 2.3%; low 3.6%; high 8.1%; and very high 9.4%. There were twice fewer observed major bleeding rate increased with the CRUSADE risk category: very low 2.3%; low 3.6%; high or very high risk of major bleeding in 24.8%, 45.7% of cases, respectively. The ARMUDA-BLEEDS study population (n = 310) for TIMI bleedings occurred. In the development set, BRS-PR could significantly discriminate between patients with and without bleeding (AUC >0.8 for all bleeding definitions). Discriminatory power of BRS-PR was significantly better than that of BRS alone (p<0.001 for all bleeding definitions). In the validation set, BRS-PR could significantly discriminate between patients with and without TIMI bleeding with an AUC of 0.788, with a better discriminatory power compared with that of BRs alone (AUC = 0.709, p = 0.036).

Conclusions: Including PR in a risk score of clinical and procedural variables improves prediction of bleeding events after PCI via the femoral approach.

TCT-297

A new prognostic risk score including platelet reactivity for bleeding after percutaneous coronary intervention via the femoral approach

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Background: Platelet reactivity (PR) may predict bleeding events after percutaneous coronary intervention (PCI), which are associated with increased risk of death. Based on a bleeding risk score (BRS) of clinical and procedural variables (bleedingrisk-score, or BARC), we developed and validated a new prognostic risk score also including PR (BRS-PR).

Methods: A total of 800 patients receiving clopidogrel and undergoing elective PCI via the femoral approach were included in this study. PR was measured immediately before PCI with the VerifyNow P2Y12 Assay. Calculation of the BRS included the following variables: age, gender, intra aortic balloon pump, glycoprotein IIb/IIIa inhibitors, chronic kidney disease, anemia, low-molecular-weight heparin within 48h pre-PCI. Low-platelet reactivity (LPR), defined as a PR value ≤178 F2Y12 reaction units, was also included in BRS-PR and assigned a weighted integer based on multivariable model of predictors of Thrombolysis in Myocardial Infarction (TIMI) bleedings. Bleeding events were monitored up to 30 days after PCI and defined according to the TIMI Randomized Evaluation in PCI Linking Angioplasty to Reduced Clinical Events (REPLACE-2) and Bleeding Academic Research Consortium (BARC) definitions. BRS-PR was also tested in the ARMYDA-BLEEDS study population (n = 310) for TIMI bleedings for validation purpose.

Results: A total of 28 (3.5%) TIMI 44 (5.5%) BARC class ≥2 and 32 (4%) REPLACE-2 bleedings occurred. In the development set, BRS-PR could significantly discriminate between patients with and without bleeding (AUC >0.8 for all bleeding definitions). Discriminatory power of BRS-PR was significantly better than that of BRs alone (p<0.001 for all bleeding definitions). In the validation set, BRS-PR could significantly discriminate between patients with and without TIMI bleeding with an AUC of 0.788, with a better discriminatory power compared with that of BRs alone (AUC = 0.709, p = 0.036).

Conclusions: Including PR in a risk score of clinical and procedural variables improves prediction of bleeding events after PCI via the femoral approach.

TCT-298

Radial versus Femoral Accesses for Percutaneous Coronary Interventions in Patients with Acute Coronary Syndromes

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Background: The purpose of this observational study was to evaluate the prognostic effects of radial artery access (RA) versus femoral artery access (FA) in patients undergoing percutaneous coronary intervention (PCI) due to acute coronary syndrome i.e. ST-elevation myocardial infarction (STEMI) and unstable angina/STEMI (UA/NSTEMI).

Methods: Data were obtained from the SCAAR registry (Swedish Coronary Angiography and Angioplasty Registry) for PCI procedures performed in Västra Götländ region in Sweden between 2005-2011. We evaluated 30-days mortality in 10007 patients, N=4386 in RA and N≈5621 in FA. The two groups were compared using Cox proportional hazards regression with “shared frailty” to account for hierarchical data. Adjustments for differences in baseline characteristics were made with propensity score. The following variables were included in the calculation of the propensity score: age, gender, indication for PCI, smoking habits, hypertension, diabetes, hyperlipidaemia, severity of coronary artery disease, previous infarction, previous PCI, previous coronary artery by-pass surgery (CABG), anticoagulation therapy with glycoprotein IIb/IIIa receptor antagonists (GP IIb/IIIa), bivalirudin, clopidogrel, unFractionated heparin/low-molecular weight heparins (UHL/MWH), year, hospital.

Results: The two groups were balanced regarding age, gender, diabetes, smoking habits, hypertension and hyperlipidaemia. RA patients were more likely to be pre-treated with aspirin, clopidogrel and to receive bivalirudin and drug-eluting stents during the procedure. FA patients were more likely to had previous myocardial infarction, previous PCI, previous CABG and to receive GP IIb/IIIa and UHL/MWH during the procedure. There were more patients (37.6% Vs 31.6% with STEMI and 62.4% (62.4%) with UA/NSTEMI. More patients with STEMI underwent PCI through FA. RA was associated with 38% reduction in 30-days mortality (1.5% Vs 2.8%; HR 0.62; 95% CI 0.44-0.87; p = 0.005).

Conclusions: Patients with acute coronary syndromes, PCI through radial artery access is associated with reduced 30-days mortality. A properly designed randomised clinical trial is urgently needed to test the hypothesis that radial artery access decreases mortality in patients with acute coronary syndrome.

TCT-299

Comparison of Slender (6.5 French Sheathless) Guiding Catheters Versus 5 French Guiding Catheters for Slender Transradial Coronary Intervention.

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Background: Transradial coronary intervention (TRI) is increasingly performed, but the standard 6 French (Fr) guiding catheters (GC) employed by most operators. Although initially on the radial system, GCs maintain the advantage of the The aim of this study is to assess the safety and efficacy of a sheathless (SH) 6.5 Fr hydrophilic-coated guiding catheter (outer diameter nearly equivalent to a 4Fr guiding catheter) compared to 5 Fr GCs in TRI.

Methods: Patients undergoing TRI between November 2008 and June 2013 were included. Baseline characteristics and in-hospital outcomes were recorded. Primary endpoints were procedural success and presence of radial pulse at discharge.