Conclusions: Complete revascularization after PCI was achieved in less than 50% of pts with ACS, and was less frequent in DM compared to non-DM pts. Patients with DM had higher rates of adverse outcomes compared to non-diabetics even when CR was achieved, and the extent of IR was less of a prognostic factor in DM compared to non-DM pts. Further strategies are required to improve the prognosis in high-risk DM pts.

TCT-323
Higher Adverse Clinical Event Rates in Young African American Women Undergoing Percutaneous Coronary Intervention: Results from the NHLBI Dynamic Registry
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Background: Prior studies suggest that younger women are at higher risk for major adverse events following PCI; however, little is known about the association between race and adverse outcomes in this population.

Methods: We evaluated 3797 women undergoing PCI in the NHLBI Dynamic Registry and compared 1 year outcomes in African American (AA) women <50 years (n=101), AA women ≥50 years (n=537), non-AA women <50 years (n=293), and non-AA women ≥50 years (n=2866) old.

Results: AA women were more likely to have hypertension, renal disease, and women: 1.1%, older non-AA women: 5.8%, p<0.001 of similar age. It is plausible that our within 1 year of PCI, including a mortality rate four times higher than non-AA women of similar age. It is plausible that our findings are due to a higher prevalence of non-cardiac comorbidities; however, secondary prevention measures and post-PCI measures post-PCI need to be explored to ensure this population is receiving optimal cardiovascular care following PCI.

TCT-324
Survival after percutaneous coronary intervention (PCI): Comparison of patients with or without Left Anterior Descending stenosis in elective percutaneous coronary intervention for left main disease and triple vessel disease
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Background: Patients with significant left anterior descending artery (LAD) disease, particularly when the proximal segment is involved, considered to have an adverse cardiac prognosis. It is reported that proximal LAD stenosis (P-LAD) have higher rates of restenosis than that in other coronary segments after angioplasty, as well as after stenting. However, the long term results of patients with P-LAD in complex coronary artery disease (CAD) have not yet been adequately studied. Our study aimed to find out if the long term mortality of patients with P-LAD among the cohort with three vessel diseases (TVD) and/or left main stenosis (LMS) higher than that without P-LAD.

Methods: Patients undergoing elective PCI with drug eluting stents (DES) for TVD and/or LMS have been included in this study. Important exclusion criteria were previous coronary artery bypass surgery, high-risk acute coronary syndrome including myocardial infarction. All-cause death was the primary endpoint of this analysis. Survival of the patients was assessed by systematic patient contacts at one, two and three years. In all patients we calculated SYNTAX score (SSc) to define the anatomic complexity of coronary artery disease and logistic EuroScore (LES) to determine the clinical risk. We used the Kaplan-Meier method to estimate the mortality. In addition, we calculated adjusted and unadjusted hazard ratios by Cox models.

Results: 1,262 patients (mean age 67.7±10.33 years, 24% female, median SSc 21.34±8.47) met the entry criteria. Median follow-up was 1197±655.05 days. P-LAD was present in 364 patients (28.8%). SSc in group with P-LAD was higher (24.69±8.24 vs. 20.8±8.36, p<0.001). There was no significant difference of one, two and three-year mortality between the group with and without P-LAD (3.0±0.9% vs. 2.9±0.6%; 5.0±1.2% vs. 5.2±1.0%; 8.0±1.5% vs. 8.2±1.0%, p=0.67; 0.64; 0.69). Hazard ratio for mortality in the presence of P-LAD was 1.08 (95% CI 0.76 – 1.54, p=0.67). Even after adjustment for SSc and LES in multivariable analysis, P-LAD was not predictive for mortality (adjusted HR 1.34 (0.94 – 1.94), p=0.11).

Conclusions: P-LAD as single criterion has no significant prognostic relevance in patients with complex CAD.

TCT-325
Revascularization Heart Team Favors Percutaneous Coronary Intervention in Patients with Intermediate and High SYNTAX when Demographic and Clinical Predictors are Included.
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Background: Randomized controlled trials in patients with complex ischemic heart disease (CIHD) suggest that patients with an intermediate/high SYNTAX score benefit from surgical revascularization. However its impact in decision making in routine clinical practice is unknown. Using a multidisciplinary Heart Team (MHT) we set out to evaluate therapeutic decision making in patients with complex IHD using SYNTAX scores combined with Society of Thoracic Surgeons (STS)-derived clinical variables.

Methods: MHT meetings consisting of interventional cardiologists and cardiac surgeons were convened to discuss management of patients with CIHD. Angiographic SYNTAX and STS risk were calculated and grouped according to risk scores Figure 1. Final recommendations on revascularization were based on consensus that factored angiographic and clinical characteristics.

Results: 201 consecutive patients underwent MHT review. Mean(SD) STS risk between groups showed; Group 1:1.4%(1.02), Group 2:7.4%(1.8), Group 3:3.1%(1.2) and Group 4:9.9%(4.8) (p<0.0001). Mean(SD) SYNTAX score showed; group 1:1.5(4.8), Group 2:16.4(7.3), Group 3:29.7(6.1), and Group 4:32.6(6.1) (p<0.0001). MHT recommendations are outlined in Table

Conclusions: Young AA women experienced higher rates of major adverse events within 1 year of PCI, including a mortality rate four times higher than non-AA women of similar age. It is plausible that our findings are due to a higher prevalence of non-cardiac comorbidities; however, secondary prevention measures and post-PCI measures post-PCI need to be explored to ensure this population is receiving optimal cardiovascular care following PCI.