METHODS Hemodynamic data were available for 140/302 patients in the SHOCK trial and 260/1189 in the SHOCK registry. We explored the number of patients meeting criteria for RVD as defined by: CVP>10mmHg, CVP/PCWP>0.63, PAPi<2.0 and RVSWI<450 mmHg·mL/m2. Next, we explored the number of patients who met the RR-RVF criteria in the trial and registry. Finally, we examined whether RVD or the RR-RVF criteria were associated with 30 day mortality.

RESULTS RVD was observed in 37% and 36% of patients in the SHOCK trial and registry respectively. RR-RVF criteria were observed in 45% and 38% of SHOCK trial and registry patients respectively. Among trial patients, RR-RVF criteria were not associated with increased 30 day mortality. Among registry patients, 30 day mortality was higher among patients who met RR-RVF criteria compared to those who did not (58% vs 44%, p=0.03). RR-RVF criteria were associated with a hazard ratio of 1.46±[1.03-2.07] (p=0.04) for 30-day mortality among registry subjects.

CONCLUSIONS RVD was commonly observed among patients in the SHOCK trial and registry. The RR-RVF criteria were associated with increased 30-day mortality in both the SHOCK trial and registry. These findings suggest that univentricular shock is uncommon in AMI-CS. Early recognition and aggressive management of RVD may improve clinical outcomes in AMI-CS. Future studies are required to further explore the potential clinical utility of the RR-RVF criteria.

CATEGORIES CORONARY: Hemodynamic Support and Cardiogenic Shock

KEYWORDS Acute myocardial infarction, Cardiogenic shock, Right Ventricular Failure

TCT-197 Abstract Withdrawn

TCT-198 Assessment Of Aortic Valve Location On Supine Chest X-ray. Applicability Of The Aortic Valve Location Ratio For Assessment Of Intra-cardiac Assist Device Position

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BACKGROUND The use of intra-cardiac assist devices is expanding and correct position of these devices is required for optimal functioning. The aortic valve is an important landmark for positioning intra-cardiac assist devices. It would be of great value if the device position could be determined accurately by plain supine chest X-ray. We aimed to introduce a ratio for determination of the aortic valve location on plain supine chest X-ray images in the intensive care unit.

METHODS Supine anterior-posterior chest X-ray of patients with an aortic valve prosthesis (n=475) were analyzed to determine the location of the aortic valve using the Aortic Valve Location (AVL) ratio. The AVL ratio was validated using computer tomography of patients with angina pectoris without known valvular disease (n=95). The position of a Impella device was determined on chest X-ray and compared to echocardiographic images (n=34).

RESULTS The AVL ratio determines the location of the aortic valve caudal to the carina, at a distance of 0.27±0.05 times the thoracic width. When the AVL ratio is used for assessment of the position of a cardiac assist device it shows a good correlation with echocardiography.

CONCLUSIONS The Aortic Valve Location Ratio enables accurate and reproducible localization of the aortic valve on supine chest X-ray. This tool is easily applicable and can be used for assessment of cardiac device position in patients on the Intensive care unit.
groups. However, there was a higher incidence of ventricular arrhythmias in the VA-ECMO group (16% vs. 50%, p = 0.02).

CONCLUSIONS Both VA-ECMO and p-VAD had similar survival and complication rates when used in patients presenting with RCS in AMI.

Choice of device in these patients should be based on operator expertise and center’s resources.

CONCLUSIONS This is a large data series collected from a single center over the last two years. These results provide additional evidence to support ECMO as a valid option for hemodynamic support in patients of a selected age group presenting with profound cardiogenic shock and respiratory failure.

CATEGORIES CORONARY: Hemodynamic Support and Cardiogenic Shock

KEYWORDS Cardiogenic shock, Extracorporeal membrane oxygenation, TandemHeart

TCT-200
ECMO for hemodynamic support in patients with profound cardiogenic shock: experience and outcomes from a large single center

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BACKGROUND Catheterization techniques can offer percutaneous way of coronary revascularization (PCI), in complex coronary lesions. In cath-lab we are able to perform high risk procedures, but we are still limited with circulatory failure at time of PCI. Commercial circulation supports (Impella®, TandemHeart® or ECMO) are expensive. We decided to develop cheap, fully percutaneous and easy to use way of circulatory support for backup at high risk PCI for conscious patients.

METHODS We modified standard tubing set for open extracorporeal circulation, we get out of the tubing kit venous reservoir and connect it only for priming, deairing system and for getting volume. Femoral artery was pre-closed by 2x ProGlide sutures and cannu- lated with 18 F cannula, femoral vein was cannu- lated with 20-22 F cannula. Blood from right atrium was drawn to the centrifugal pump, continue to the oxygenator and through arterial cannula. Blood from right atrium was drawn to the centrifugal pump, continue to the oxygenator and through arterial cannula. UFH was given and circulation started at ACT 400 sec. For PCI we used contralateral groin, pressure was recorded from sheat sideport. At the end UFH was reversed to ACT 250 sec, arterial puncture was closed with sutures, venous with manual compression.