

protocol was initiated in 36 patients with a average baseline blood glucose 2.7 ± 0.7 g/l. thirty-two were diabetics (31 type 2 and 1 and type 1) and diabete mellitus has been found on the occasion of the SCA in 4 of them with HbA1c $>6.5\%$. The average time to reach a glycemia within the target range was 12.7 ± 11 h. Only 3 patients (8%) had moderate hypoglycemia (<0.70 g / l) and there were no severe hypoglycemia.

Conclusion: In this study, 59% of patients are diabetics, know or revealed at the opportunity of SCA, higher than the usual literature data. Hyperglycemia at admission reveals glucose disorder in 53% of cases. Our IV insulin protocol is safe and efficient.

0063

Radial vs femoral access after percutaneous coronary intervention for ST-segment elevation myocardial infarction. Thirty-day and one-year mortality results in Algerian cohort

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Introduction and Objectives: Little attention has been given to the effect of vascular access site on mortality, while an increasing body of evidence is showing that radial access has much more benefit than femoral access for ST-segment elevation myocardial infarction patients. We aimed to assess the influence of vascular access site on mortality at 30 days and at 1 year in ST-segment elevation myocardial infarction patients.

Methods: We included all patients with ST-segment elevation myocardial infarction who had undergone angioplasty at military hospitals of Constantine and Algiers and the hospital of erriadh (ESH erriadh) between 2010 and 2013. We performed 2 multivariate regression models for each endpoint (30-day and 1-year mortality). The only difference between these models was the inclusion or not of the vascular access site (femoral vs radial). We also tested the interaction between hemodynamic instability and vascular access.

Results: We included 395 patients with a mean age of 62. Of these patients, 32% had radial access and 7.4% had hemodynamic instability. All-cause mortality was 8.6% (34/395) at 30 days and 13.1% (52/395) at 1 year. Vascular access site follows hemodynamic instability and age in terms of effect on mortality risk, with an odds ratio of 5.20 (95% confidence interval, 2.80-9.66) for 30-day mortality. A similar effect occurs for 1-year mortality.

Conclusions: Vascular access site should be taken into account when predicting mortality after a primary percutaneous coronary intervention.

0064

Effect of acute heart failure following discharge in patients with non-ST elevation acute coronary syndrome on the subsequent risk of death or acute myocardial infarction: Algerian experience

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Introduction and Objectives: Little is known about how prognosis is influenced by readmission for acute heart failure (AHF) following non-ST-segment elevation acute coronary syndrome (NSTEMACS). The aim of this study was to determine the prognostic effect of a first admission for AHF on the risk of acute myocardial infarction (AMI) or death in patients who survived an episode of high-risk NSTEMACS.

Methods: The study involved 342 consecutive patients with high-risk NSTEMACS who survived after hospital admission in military hospital of Algiers and Constantine. Readmission for AHF was selected as the main exposure variable, and its association with subsequent AMI or all-cause death was assessed using Cox proportional hazards models for time-dependent covariates that also included adjustment for competing risks. **Results:** After a median follow-up period of 30 [interquartile range, 12-48] months, 29 patients (8.4%) were admitted for AHF, 51(15%) had an AMI, and 71 (20.8%) died. The median time to readmission for AHF was 193 [56-336] days after NSTEMACS. Patients readmitted for AHF had an increased risk of subsequent death (hazard ratio [HR]=1.67; 95% confidence interval [CI], 1.13-2.45;

P=.009) or AMI (HR=2.15; 95% CI, 1.41-3.27; P<.001), which was independent of baseline prognostic and time-dependent variables.

Conclusions: Readmission for AHF after high-risk NSTEMACS was associated with an increased risk of subsequent death or AMI.

0447

Optimal therapeutic management improves long-term survival in ST-elevation myocardial infarction patients with altered glomerular filtration rate. A propensity score comparison

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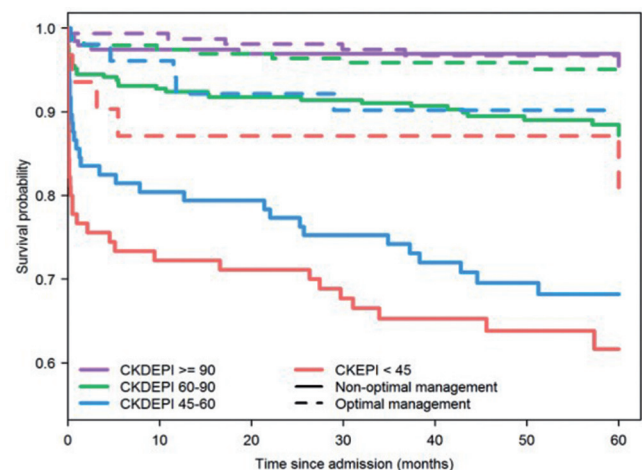
Introduction: Decreased glomerular filtration rate (GFR) is associated with an increased risk of cardiovascular events following acute ST elevation myocardial infarction (STEMI). However, patients with chronic kidney disease have more comorbidities and will receive fewer evidence-based therapies

In a prospective STEMI patient cohort we assessed the effect of an optimal therapeutic management (OTM) according to GFR categories on long-term all-cause mortality.

Methods: In a single tertiary referral center, 1,199 patients admitted for acute STEMI were enrolled between 2007 and 2011. We classified patients into 4 categories according to estimated GFR, <45 , 45 to 60, 60 to 90, and >90 ml/min/1.73m² with the Chronic Kidney Disease Epidemiology Collaboration (CKD EPI) equation. Optimal therapeutic management was defined as a combination of reperfusion within 12 hours of symptom onset, primary percutaneous coronary intervention (PCI), double anti-platelet regimen, angiotensin converting enzyme inhibitors, statins, beta blockers, and anti-aldosterone treatment (if left ventricle ejection fraction $<40\%$) upon discharge. The effect of OTM on survival according to GFR categories was analysed in a multivariate survival model including other risk factors and using a propensity score method. Long-term mortality was the principal endpoint.

Results: Patients were followed-up for a median of 4.7 years and 148(12.3%) patients died. OTM was applied in 431 (39.1%) patients of our cohort and overall, was associated with a significantly lower mortality (HR of 0.43 [95% CI, 0.26-0.70; P<0.001). There was a significant mortality reduction in the OTM group compared to the non-OTM group that tended to increase with increasing levels of renal dysfunction (HR of 0.28 [95% CI, 0.13-0.61] in the eGFR<60ml/min subgroup; P=0.001) (Figure 1).

Conclusions: OTM lowers long-term mortality whatever the eGFR category and with a trend towards increased efficiency with increasing levels of renal dysfunction.



Abstract 0447-Figure