forçably extracted with the guidewire in 4 lesions; retrieved with the two-guidewire technique in one lesion; and retrieved after the imaging core was removed in 5 lesions. In these 5 lesions, (1) we cut only the outer envelope of View IT catheter; (2) removed the imaging core (3) put the distal part of 0.014 inch coronary guidewire into the envelope; and (4) pulled the IVUS catheter. Stent deployment was angiographically observed in 5 lesions (forcibly extracted in 3 lesions, removed the imaging core in 2 lesions), and post stent dilatation was performed in 6 lesions. All patients with IVUS entrapment were successfully managed percutaneously and discharged without any other complication including stent thrombosis.

Conclusions: Entrapment of an IVUS catheter was an infrequent complication of PCI. Retripping imaging core was an alternative technique to retrieve an entrapped IVUS catheter.

TCT-346
Race and Outcomes after PCI for ACS: A Pooled Analysis of the HORIZONS-AMI and ACUITY Trials
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Methods: Data from 41,126 patients undergoing PCI for ACS from the HORIZONS-AMI and ACUITY trials were pooled. Patients were stratified by race (non-white vs. white), and adverse outcomes were assessed with propensity-adjusted multivariable analysis at 30-day and 1-year time points.

Results: Among the total PCI cohort, 10,128 patients (9.1%) were non-white. Non-white patients were younger, more likely to be women, diabetic, hypertensive, and to have experienced prior myocardial infarction and coronary revascularization. Presenting chest pain was older (69 vs 64 years), more African American (46.2% vs 28.0%), had more diabetes mellitus (41.5% vs 35.9%) and more history of chronic kidney disease (25% vs 15.3%), compared to those without stroke (all p <0.05). Multivariable logistic regression analysis identified IABP as the strongest predictor for stroke, followed by African American race, a history of diabetes mellitus, and the presence of ST-segment elevation myocardial infarction at baseline.

Conclusions: These data suggest that a CM volume of 4.93 ml/CyC might be a useful indicator for determining the safe CM dose based on eGFR value before PCI.

TCT-347
The Efficacy of Cystatin C Based Glomerular Filtration Rate in the Estimation of safe contrast media volume.
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Background: The risk of contrast-induced nephropathy (CIN) is significantly influenced by baseline renal function and amount of contrast media (CM). Despite commonly usage in clinical practice, serum creatinine has significant limitations in accuracy. Therefore we evaluated the usefulness of the cystatin C (CyC) based estimated glomerular filtration rate (eGFRCyC) in prediction of CIN and to determine safe CM dose.

Methods: We prospectively enrolled a total of 723 patients who received percutaneous coronary intervention (PCI) and investigated clinical factors associated with development of CIN. Renal function was calculated as eGFRCyC and a modified diet in renal disease (MDRD) equation, respectively. Systemic exposure of CM was calculated as CM volume to eGFR ratio. We conducted a regression analysis to evaluate the predictive role of CM volume to eGFRCyC for risk of CIN.

Results: The incidence of CIN was 4.0% (29/723). The patients with CIN had lower hemoglobin level, more decreased renal function, and higher CyC value, and greater CM exposure. On multivariate regression analyses, hemoglobin (Odds ratio (OR) 0.743, p=0.032), CM volume/eGFRCyC (OR 1.697, p=0.006) and CM volume/MDRD (OR 2.275, <p=0.001) were found to be independent predictors for CIN. In receiver operating characteristic curve analysis, fair discrimination for CIN was found at a CM volume/eGFRCyC level of 4.493 (C-statistics = 0.814), and at this value, the sensitivity and specificity were 79.3% and 80.0%, respectively.

Conclusions: These data suggest that a CM volume/eGFRCyC method would be a simple, useful indicator for determining the safe CM dose based on eGFR value before PCI.

TCT-348
Incidence, Correlates And Outcomes Of Percutaneous Coronary Intervention Related Stroke In The Last Decade
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Background: Stroke is a rare complication from percutaneous coronary intervention (PCI) and is usually associated with high morbidity and mortality. This study was conducted to review the contemporary incidence and predictors of peri-procedural stroke related to PCI.

Methods: A total of 23,117 patients who underwent PCI from 2002 to 2012 in our center were analyzed.

Results: A total of 64 patients suffered with PCI-related stroke. Overall, the rates of stroke remained constant over the past 10 years (p=0.09) with an incidence of peri-procedural stroke per year of 0.24% ± 0.15%. Patients with stroke were older (69 ± 11 vs 65 ± 13 years), were more African American (46.2% vs 28.0%), had more myocardial infarction during admission (54.7% vs 29.8%), more insulin dependent diabetes mellitus (41.5% vs 35.9%) and more history of chronic kidney disease (25% vs 15.3%), compared to those without stroke (all p <0.05). Multivariable logistic analysis identified IABP as the strongest predictor for stroke, followed by African American race, presentation with myocardial infarction and increasing age. (Figure) For patients with peri-procedural stroke, the in-hospital length of stay was longer (12 ± 11.3 vs 3 ± 4 days, p <0.001) and with higher in-hospital mortality (29.2% vs 1.4%, p <0.001), compared to those without stroke.

Conclusions: The rates for PCI-related stroke were low and have remained stable over the last decade. However, for complex patients requiring IABP, closer stroke mitigation strategies should be considered.