patients, age ranging from 25 to 101 years. Ninety two patients presented in CS. We did not perform Allen’s test in any patients, presence of pulse was enough to proceed. We assessed in-hospital complications.

RESULTS Out of all patients, 94.6% patients underwent PCI through TR-TU vascular
to assess in-hospital complications.

CONCLUSION Systemic vascular function is not associated with coronary no reflow.

RESULTS Thirty consecutive patients with STEMI and normal
coronary no-re.

INTRODUCTION Coronary no-reflow during primary PCI is a predictor of poorer cardiovascular outcome. Both endothelial dysfunction and no-reflow involves abnormal vascular function and hemorrhosis. Therefore, our aim was to assess the association between risk factors, endothelial dysfunction and no reflow during primary PCI.

METHODS Thirty consecutive patients with STEMI and normal flow during primary PCI were compared to 19 consecutive patients who had no reflow. All subjects under
to the EndoPAT device.

RESULTS Age, sex, and frequency of hypertension were similar in both groups. Smokers were less likely to have no-reflow (Table). Post PCI there was less ST-segment resolution in the no-reflow group (48%±7 vs 81%±6; p=0.001). Patients who had no reflow had subsequently lower ejection fraction (39±10 vs 47±10; p=0.015). There was no difference in vascular function (RIH) between groups. (Figure)

CONCLUSION Systemic vascular function is not associated with coronary no reflow.

### CRT-106

**Endothelial Dysfunction is Not Associated With No-reflow During Primary PCI**

Ayyaz Sultan, Mistre Alemayehu, Shahar Lavi

**INTRODUCTION** Coronary no-reflow during primary PCI is a predictor of poorer cardiovascular outcome. Both endothelial dysfunction and no-reflow involves abnormal vascular function and hemorrhosis. Therefore, our aim was to assess the association between risk factors, endothelial dysfunction and no reflow during primary PCI.

**METHODS** Thirty consecutive patients with STEMI and normal flow during primary PCI were compared to 19 consecutive patients who had no reflow. All subjects underwent assessment of endothelial function (reactive hyperemia index: RIH) within 48-72 h post PCI using the EndoPAT device.

**RESULTS** Age, sex, and frequency of hypertension were similar in both groups. Smokers were less likely to have no-reflow (Table). Post PCI there was less ST-segment resolution in the no-reflow group (48%±7 vs 81%±6; p=0.001). Patients who had no reflow had subsequently lower ejection fraction (39±10 vs 47±10; p=0.015). There was no difference in vascular function (RIH) between groups. (Figure)

**CONCLUSION** Systemic vascular function is not associated with coronary no reflow.

### CRT-107

**Abbreviated versus Standard EptiPhiplate Infusion in ST Elevation Myocardial Infarction- Outcomes and Predictors of Complications**

Alizea Bagheri, Farrukh Hassian, Seeger Shen, Kerrett Wallace, Chris Haye, Steve Promislov

**BACKGROUND** Glycoprotein IIb/IIIa inhibition has been a mainstay in acute myocardial infarction intervention. Major bleeding is a predictor of adverse outcomes in ST elevation myocardial infarction (STEMI).

**OBJECTIVES** To determine the safety and bleeding outcomes of abbreviated compared to standard infusions of the glycoprotein IIb/IIIa inhibitor epti-phi-plate in the setting of primary PCI for STEMI.

**METHODS** We analyzed a retrospective cohort of 93 STEMI patients who received abbreviated (<18 hours) infusion of epti-phi-plate and compared them to 91 STEMI patients with standard (18 hours) infusion in primary PCI, from June 2009 to June 2011, at a single cardiac centre. Detailed chart review of demographic and clinical characteristics, times to intervention, complications, electrocardiographic (ECG) findings, bleeding, ejection fraction (EF), and stent thrombosis data was performed. Descriptive statistics were utilized to outline safety and efficacy outcomes. A p-value < 0.05 was considered significant.

**RESULTS** There was no significant difference between the two groups in complications including GI bleeding, hematoma larger than 5 cm, fistula or pseudo-aneurysm, retroperitoneal hemorrhage (RPH) or hemoglobin drop more than 50 g/L. Closure devices were deployed more in abbreviated infusion (65% vs. 44%, p-value: 0.004). There was a trend towards improved ST elevation resolution > 50% in standard infusion (78% vs. 66%, p-value: 0.06) and CK peaked higher in abbreviated infusion (2088.9 ± 1982 vs. 1565 ± 1545, p-value: 0.03). There was no significant difference in stent thrombosis or EF (47.25% ± 9.46 vs. 49.4% ± 9.2 for abbreviated and standard infusion respectively, p-value: 0.12). There was no significant difference in transfusion (3% vs. 5% for abbreviated and standard infusion respectively, p-value: 0.44) or death (3.2% vs. 1.1% for abbreviated and standard infusion respectively, p-value: 0.37).

**CONCLUSIONS** Abbreviated duration glycoprotein IIb/IIIa inhibition may be a safe and novel alternative to standard infusion during STEMI. Although there was no significant difference in bleeding or vascular complications between abbreviated and standard infusion groups, along with a trend towards better ST resolution and lower CK in standard infusion group, but there was no significant difference in stent thrombosis, EF or death between the two groups. Further large prospective randomized controlled trials are indicated to study this approach to reduce bleeding in this high risk population.