SHA 55. Door to ER-door to early reperfusion therapy by primary angioplasty time-path for quality management
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Objectives: Early reperfusion treatment is crucial for patients who have myocardial infarction with ST-segment elevation. Guidelines recommend that the interval between arrival at the hospital and intracoronary balloon inflation (door-to-balloon time) during primary percutaneous coronary intervention should not exceed 90 min and must not exceed 30 min if the treatment choice was early reperfusion by lytic therapy (door to needle). However, few hospitals meet this objective. We sought to identify hospital strategies that were significantly associated with a faster door-to-balloon time. The main objective of the study is to measure our performance related to fast treatment of patients with ST elevation MI. The study aims to measure the time between door to ER and door-to-balloon and compare the results to the literature and the standard recommendations by AHA 2005.

Methods: We established a special auditing tool contains all factors associated with delay in performing early reperfusion therapy by primary angioplasty.

Results: In analysis of the audits most of the delay was related to the time performing 12 lead ECG and the time to transfer the patient from ER to the Cardiac Cath lab then the time the Cath lab team arrived to hospital.

Conclusion: Several specific hospital strategies are associated with a significant reduction in the door-to-balloon time in the management of myocardial infarction with ST-segment elevation. It is recommended to repeat the audit periodically and to conduct it as per focus PDSA cycled as project for quality management in order to monitor our performance and improve our care.

Tracks: Cardiac Nursing.
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SHA 56. Old age does not have an adverse effect on survival in patients undergoing combined coronary grafts and valve surgery
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Objectives/Background: The increase in life expectancy with therapeutic improvements together with increased age related incidence of ischemic and valvular heart diseases lead to greater number of patients with advanced age who presents for combined cardiac operations.

Aim: We aimed to answer the question of: are patients over 75 years of age associated with poor survival in combined operations? and to identify independent risk factors that predict survival in patients undergoing these procedures.

Methods: Data were collected prospectively from 476 patients who underwent combined procedures at Kings College Hospital between 1998 and 2004. Patients were divided into two groups, group A: 341 patients under the age of 75 years and group B: 136 above age of 75 years. In-hospital mortality was used for survival analysis. Statistical analysis was performed using Stata 6.

Results: Median age was 71 years (range 26–88). Three hundred and twenty six (68%) patients were male. In addition to the coronary grafting, 339 (71%) patients had operation on aortic valve, 132 (27.7%) on the mitral valve, 5 (1%) on both valves and 1 (0.2%) on the tricuspid valve. The following were identified as an independent predictors of in-hospital mortality; female sex (OR 3.193, CI 1.118–8.589, P = 0.022), and emergency surgery (R 346.5, CI 27.282-4400.793, P = 0.043).

Conclusion: Age does not influence survival and patients above 75 years should not be denied combined cardiac surgery based on old age alone.

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SHA 57. Cardiac surgery in nonagenarian. Should we operate?
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Objectives: Growth of the elderly population worldwide will continue to accelerate and will have a profound impact on health care resources in the future. Patients aged 90 years and older represent a rapidly growing subset of this population, many of whom are functionally limited by cardiovascular disease. The question to operate or not to operate is still debatable. The aim of this study was to review our local experience with nonagenarians concerning postoperative morbidity, mortality, and long-term survival status.

Methods: A consecutive series of nonagenarians (14 patients) who underwent cardiac operations between June 2007 and May 2009 were retrospectively reviewed. Data collection included baseline preoperative clinical status, intraoperative characteristics, and perioperative course and short-term outcomes. These recorded data were analyzed.

Results: There were two women (14.3%) and 12 men (85.7%). There were six coronary artery bypass grafting (CABG) procedures (43%), three aortic valve replacements (AVR) (21.5%), one combined MVR and CABG (7%), tow combined AVR and CABG (14%), one double valve procedure (7%) and one removal of left atrial clot (7%). Thirty-day mortality was 14% (2 deaths total; one operative death and one cardiac arrest at ICU day 2 postoperative). Short-term follow up (range, 3 weeks to 2 years), 11 patients 78.5% are still alive. One patient is missing follow up. Nine patients (70%) have quality of life outcomes similar to that of related norm-based populations based on age and disease process.

Conclusion: Although morbidity, mortality, and cost may be higher in nonagenarian, advanced age itself (>90 years) should not be a contraindication to an open-heart operation. With improving techniques and greater attention to detail, the select