sites performed in 31%, and additional thrombolytic agents given in 23% of cases. PCI was angiographically successful in 86%, but the in-hospital mortality was 28%. The post-PCI length of stay was 7.0±7.7 days. Additionally, 1.7% had a CVA, 6.2% had renal failure (RF), and 5.4% had vascular complications. Age was the single most predictive variable: mortality was 11.2% for ages up to 50; 20.0% for ages 51-60; 27.2% for ages 61-70; 34.8% for ages 71-80; 43.3% for ages above 80. Stenosis morphology (as A, B1, B2 or C) was not predictive. Logistic regression identified six multivariable predictors of death: age (odds ratio 1.001 for each 10 year increment); EF (p=0.001, 0.76 (0.70, 0.82) for each 10% decrement); diabetes (p=0.001, 1.65 (1.28, 2.12)); RF (p=0.005, 1.98 (1.35, 2.90)); prior PCI (p=0.01, 0.69 (0.51, 0.93)); and urgent or emergent PCI (p=0.001, 0.32 (0.23, 0.53) and 2.54 (1.64, 3.51)). The model showed good discrimination with a ROC of 0.776, validated 0.736. Calibration was excellent, permitting development of a nomogram to estimate risk to over 60%.

Conclusion: Thus, mortality after PCI for CHD depends primarily on several historical and clinical variables known to the physician at the time of decision for PCI. Patients may be individually stratified as to risk of death.

1125-7
Emergency CABG After Failed PCI in Contemporary Practice: A Report From the ACC-NCDR Registry

Background: The increased use of coronary stents and glycoprotein IIb/IIIa inhibitors over the past five years has resulted in a marked decrease in the need for emergency coronary artery bypass surgery (em CABG) after failed PCI. However, situations still occur that require the availability of surgical options.

Methods: To characterize clinical and angiographic findings predisposing to em CABG in contemporary practice, the 100,253 consecutive PCI procedures performed from 1998-2000 at 145 institutions contained in the ACC-NCDR database were analyzed.

Results: 371 (0.4%) of PCI procedures required em CABG. The average age was 63±12 years, 64% were men, 70% had prior CABG, and 27.6% prior PCI. Stents were placed in 29.1% of cases, and 1.7% (vs. 71% in the total registry) lib/Ilia agents used in 41.2% and thrombolytics in 29.1% (vs. 71% in the total registry), lib/Ilia agents used in 41.2% and thrombolytics in 29.1% (vs. 71% in the total registry).

Conclusion: The need for em CABG in contemporary PCI is very low, but when required it carries serious mortality and morbidity implications. A disturbing percentage of cases requiring em CABG consist of what are usually thought of as "low-risk" elective procedures with non-complex stenosis morphologies and/or totally occluded vessels. Tamponade or the inability to deliver a stent may influence the decision process. Thus, there is still a role for surgical standby and em CABG options in contemporary practice.

1125-8
A Double Blind Placebo-Controlled Randomized Trial of Fluvastatin After Successful Percutaneous Intervention in Patients With Coronary Heart Disease: The Lesclo Intervention Prevention Study (LIPS)
Patrick W. Serruys, on behalf of the LIPS Investigators, Thoraxcenter, Erasmus University Hospital, Rotterdam, The Netherlands.

Background: Based on evidence from large clinical trials of subjects with and without coronary heart disease (CHD) or myocardial infarction (MI), statins are now well-established as the primary and secondary prevention of fatal and non-fatal coronary events; however, no study has prospectively evaluated the long-term effect of statins on clinical outcomes in patients who have undergone PCI.

Methods: LIPS is a double-blind, randomized trial designed to compare the effect of fluvastatin (40 mg bid) on major adverse cardiac event (in MACE [cardiac death, non-fatal MI, repeat-CABG or PCI-free survival time in 1877 patients with CHD and successful PCI over a 3 year follow-up]. Secondary endpoints are the incidence of MACE, non-cardiac deaths, hospitalization for other atherosclerotic diseases, changes in serum lipid concentrations, and anginal status. I nclusion criteria were: ages 18-80 years; first successful PCI within 6 months before randomization; total cholesterol of 135 - 270 mg/dL (3.5 - 7.0 mmol/L) with fasting triglycerides <400 mg/dL (<4.5 mmol/L) in the absence of any lipid-lowering therapy for at least 6 weeks. Baseline characteristics were as follows:

<table>
<thead>
<tr>
<th>Mean age (y)</th>
<th>60.5±10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male (%)</td>
<td>84.0</td>
</tr>
<tr>
<td>Smoking (%)</td>
<td>26.6</td>
</tr>
<tr>
<td>Body Mass Index (kg/m²)</td>
<td>26.6±3.3</td>
</tr>
<tr>
<td>Blood pressure (mm Hg)</td>
<td>128.0±7.5</td>
</tr>
<tr>
<td>Heart rate (bpm)</td>
<td>66.0±11</td>
</tr>
<tr>
<td>Diabetes mellitus (%)</td>
<td>12.0</td>
</tr>
</tbody>
</table>

Total Number Of Lesions Treated 2222.0

Summary: LIPS is the first study to investigate the effects of statin therapy on MACE in patients who have undergone successful primary TCT for CHD. Final results will be presented.

1125-9
Two-Year Outcomes Following Percutaneous Intervention: Beamant Angiotensin Converting Enzyme Genotype and Endpoints Trial (The BAGET Trial)

Background: The angiotensin converting enzyme (ACE) genotype has been correlated with adverse cardiovascular events. This study was designed to determine if the ACE genotype was predictive of target vessel revascularization (TVR), myocardial infarction (MI), and mortality following percutaneous intervention.

Methods: We prospectively analyzed the ACE genotype (D/D, D/I, I/I) in 758 patients undergoing percutaneous intervention to determine clinical restenosis and mortality at two year follow up. We analyzed baseline clinical parameters, angiographic details and outcomes in patients with D/D (255 patients) vs D/I (344 patients) vs I/I (154 patients).

Results: Thus far in the D/D vs D/I vs I/I groups there is no difference in history of hyper-tension (76% vs 77% vs 71%, p=NS), hyperlipidemia (76% vs 74% vs 63%, p=NS) or smoking (69% vs 74% vs 70%, p=NS). No difference in age (65±11, 65±11, 62±13, p=NS) or female gender (27% vs 24% vs 26%, p=NS) is seen. No difference in use of ACE inhibitors (46% vs 49% vs 42%, p=NS) or angiotensin receptor blockers (8% vs 11% vs 14%, p=NS) is seen between the groups. History of diabetes mellitus (34% vs 32% vs 33%, p=NS), coronary artery disease (85% vs 81% vs 84%, p=NS) and MI (53% vs 51% vs 54%, p=NS) are not different between groups. TVR is not affected by genotype (23% vs 21% vs 15%, p=NS), the combination endpoint of TVR, MI and death did not differ by genotype as well (27% vs 26% vs 24%, p=NS).

Conclusions: These findings suggest that the ACE genotype does not correlate with TVR, MI or death at 2 years following percutaneous intervention. Therefore ACE geno-typing is not a useful test for risk stratification at the time of percutaneous intervention.

1125-10
Gender Differences in Mortality After PTCA, According to Age
Emir Velidar, Jerome L. Abramson, Elizabeth M. Mahoney, William S. Weintraub, Viola Vavcanin, Emory University School of Medicine, Atlanta, Georgia.

Background: Younger women hospitalized for myocardial infarction are a high-risk group compared to men, with higher short and long-term mortality. This gender difference is less pronounced at older ages. We sought to determine whether younger women are also at increased risk of in-hospital mortality after PTCA compared to men, and whether this gender difference becomes less pronounced with advancing age.

Methods: We studied 150,919 patients included in the National Cardiovascular Network (NCHN) database who received PTCA at 23 clinical centers between October, 1993, and June, 2000, and for whom outcome information was available.

Results: In logistic regression models that adjusted for demographics, medical history, prior PTCA, prior CABG, height, weight, renal insufficiency, LVEF, number of diseased vessels and elective admission, women had a higher odds of death compared to men. This greater risk was most pronounced in the youngest age group. Among patients <50 years old, the odds of death was 2 times higher in women compared to men. However, this gender difference was less substantial in older age groups.

Conclusion: Younger women undergoing PTCA are at a substantially higher risk of in-hospital mortality compared to younger men, even after adjustment for traditional risk factors. At older ages, women are at only slightly higher risk of mortality compared to men. The reasons for the higher post-PTCA mortality risk in young women compared to young men need investigation.