

diabetic chronic treatments (40% for both), and 27% were on insulin therapy. The other antidiabetic medications, including glinide, glitazone, and acarbose were rarely used (3%, 2%, and 5%, respectively). Mean baseline and post PCI Cr levels were 102 ± 52 and $122 \pm 81 \mu\text{mol/L}$. Rate of CIN was similar in patients with or without metformin (21 vs 20%, respectively, $p = 0.87$). Logistic regression for the risk of CIN taking into account classical risk factors showed no impact of chronic metformin therapy, even in stratified analysis in patients with chronic kidney disease. Hospital mortality was similar between groups (7 vs 6%, respectively, $p = 0.69$). Moreover, no case of lactic acidosis was reported during the hospital stay.

Conclusion: In this multicentre study reflecting current clinical practice, metformin treatment prior to primary PCI had no significant impact on CIN. Larger studies are needed to confirm these findings.

0474

The deleterious cardiovascular impact of renal failure varies according to PCI indication

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Aim: To compare cardiovascular (CV) outcomes after contemporary PCI in patients with vs. without renal failure (RF) according to clinical presentation (ST-elevated myocardial infarction (STEMI), acute coronary syndrome (ACS), and stable coronary artery disease (sCAD)).

Methods: Consecutive patients undergoing PCI with stent implantation were prospectively included from 2007 to 2012. RF was defined by a CrCl $< 60 \text{ ml/min}$. The primary end-point was all cause-mortality. The secondary endpoints were MACCE (cardiovascular death, myocardial infarction, stroke, TLR), TLR (target lesion revascularization), and ARC definite/probable stent thrombosis (ST) at one year.

Results: Among 5337 patients eligible, 1219 (23%) had PCI for STEMI, 1837 (34%) for ACS and 2281 (43%) for sCAD. There were 1441 (27%) patients with RF. At one year, patients with RF had increased all-cause mortality rates whatever the indication for PCI (Figure), with a 6 fold higher unadjusted all-cause mortality rate in STEMI patients (41% vs. 7.5%) and a 3 fold increase in ACS (19% vs. 6%) and sCAD (10% vs. 3%) patients compared to noRF patients ($p < 0.0001$ for all comparisons). MACCE were also higher in RF patients in each PCI indication (45% vs. 15% in STEMI, 23% vs. 14% in ACS, and 14% vs. 9% in sCAD, $p < 0.05$ for all). STEMI-noRF patients had comparable mortality ($p = 0.209$) and MACCE rates ($p = 0.658$) than sCAD-RF patients. TLR ranged from 5.5% to 7.4%, and definite/probable ST was $< 2.5\%$ without any difference in each PCI indication ($p > 0.05$ for both). After multivariable analyses, RF was independently associated with an excess of death with a more than doubled relative risk in STEMI compared to ACS and sCAD patients (OR 5.3; CI 3.627-7.821 in STEMI vs. 2.1; CI 1.465-3.140 and 2.3; CI: 1.507-3.469 in ACS and sCAD, respectively, $p < 0.0001$).

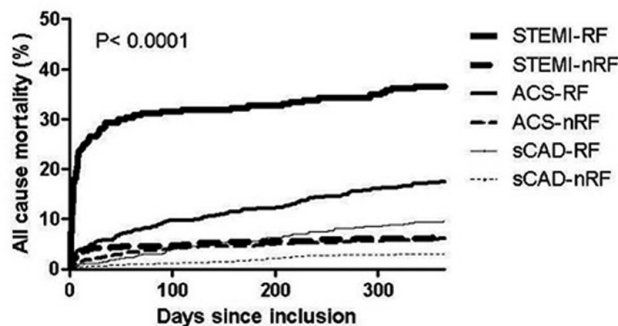
Conclusion: RF is a stronger independent predictor of death after PCI in patients with STEMI compared to patients with ACS and sCAD. CV prognosis of sCAD-RF patients was found to be comparable to that of STEMI-noRF patients.

0165

Outcome after drug-eluting stents for cardiac allograft vasculopathy

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Purpose: Cardiac allograft vasculopathy (CAV) constitutes a primary cause of death after heart transplantation. Bare metal stents (BMS) have been used for revascularization, but they are associated with a high-risk of restenosis.



Abstract 0474 – Figure: Kaplan-Meier estimates of one-year mortality

Limited data have shown favourable results with percutaneous coronary interventions (PCI) using drug-eluting stents (DES) in this specific population. Our study focuses on intra-stent restenosis (ISR) for DES in CAV, on new revascularisation and mortality.

Methods: 97 consecutive heart transplant recipients with successful PCI were treated with DES ($n = 106$) and BMS ($n = 25$). They were prospectively followed-up at one year after PCI. An angiographic lesion-based analysis at 12-month follow-up and a patient-based survival analysis were performed.

Results: The lesion-based analysis within 12 months after PCI showed an ISR rate with BMS of 12% and an ISR rate with DES of 3.8%. The target lesion revascularization (TLR) was 8% for BMS and 2.8% for DES. However, the target vessel revascularization was higher (16.5%) and the remote lesion revascularization was 8.7%, indicating the rapid occurrence of new significant lesions. Cardiac mortality at one year was 9.7% and extra-cardiac mortality was 2.9%.

Conclusions: DES are associated with a low rate of TLR and can safely be used in heart transplant recipients with coronary artery disease. However, new significant lesions occurred at one year indicating a progression of CAV.

0207

Outcome of patients after resuscitation from out of hospital cardiac arrest: the role of percutaneous coronary intervention in Clermont-Ferrand university hospital

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Background: The hospital cardiac arrest (ACEH) represent the leading cause of death worldwide. Despite improvements in their care, the prognosis of these patients remains very pejorative, including those who have received initial resuscitation success. The objective of this study was to evaluate the influence of emergency coronary angiography (CAG) and primary percutaneous coronary intervention (PCI) on the outcome of patients survivors after out-of-hospital cardiac arrest and living in ICU in the Auvergne region namely coronary angiography.

Methods: During 18 months, a cohort of surviving patients admitted alive in Aceh and resuscitation was incorporated in the CHU Gabriel Montpied. All demographics, pre-hospital and hospital were analyzed. The multivariate analysis of prognostic factors in this cohort used mainly the Cox model.

Results: 54 consecutive patients with out-of-hospital cardiac arrest survivors underwent systematic emergency coronary angiography. Most (65%) OHCA survivors had angiographic coronary artery disease: occlusion in 23 patients (43%) and significant stenosis in 12 patients (22%). Angioplasty was attempted in 20 patients and was technically successful in 18. Chest pain and the presence of ST-segment elevation were poor predictors of acute coronary-artery occlusion. Hospital survival was 48%. By multivariable analysis, use of PCI was an independent factor of survival ($p = 0.006$).

Conclusion: Acute coronary-artery occlusion is frequent in survivors of out-of-hospital cardiac arrest and is predicted poorly by clinical and electro-