

uncertain severity and were subjected to FFR. 37 out of 58 lesions (68.8%) had diameter stenosis <70% and 21 (31.2%)  $\geq$  70%.

Decision to revascularize the vessel or to defer the procedure was changed for 12 lesions (20.6%) based on an FFR cut-off value of  $\leq$  0.8. Of these, 4 lesions (33%) were < 70 % stenosed and 8 were  $\geq$ 70% (66.6%). In 8 cases FFR led to deferral of procedure and in 4 cases it led to intervention (3 PCI, 1 CABG). In other cases it served to validate the angiographic decision. The decision change was commonly in favour of deferral (8 out of 12 lesions) but led us to perform procedure in 4 cases. Performance of FFR in 40 cases (58 lesions) with coronary lesions of intermediate/uncertain severity led to avoidance of 8 stents in non-significant lesions and permitted the additional treatment of 4 lesions that required intervention. This is expected to improve the clinical results and save cost although long term outcome and cost benefit were not part of the study.

**Conclusion:** FFR provides a reliable and objective assessment of intermediate/uncertain lesions leading to better revascularization decisions. There is significant inter-observer variability between cardiologists when assessing intermediate/uncertain lesions and FFR changes decisions even when the subjective decision is unanimous.

In our experience of intermediate / uncertain coronary lesions FFR changed the treatment assignment in 20.6% leading to the avoidance of stents in 8 lesions and appropriate revascularization in 4 additional lesions. Angiographic decisions of experienced operators differed in 25% of intermediate/uncertain lesions. FFR also changed the treatment assignment in 18.2% of lesions where the angiographic assessment was unanimous, further attesting to the need for objective functional testing in these cases.

A larger study along with cost benefit analysis and follow up data may be planned to further clarify these results.

### Role of FFR in evaluation of renal artery stenosis

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**Background:** Angioplasty for renal artery stenosis is mired in controversies, especially with regard to the late outcomes. This is further complicated by vagaries in visual assessment of percentage of stenosis and the significance of the lesion. We sought to determine if FFR can throw light on this dilemma.

**Methods:** Twenty one patients diagnosed to have significant renal artery stenosis (>70%) by conventional angiography, were subjected to FFR before elective intervention. A value of less than 0.85 was taken as significant on FFR.

**Results:** Out of twenty one patients subjected to FFR significance of <0.85 was demonstrated in seven patients only. Rest of the patients had an FFR ranging between 0.86-0.98.

In the FFR negative group, 5 underwent angioplasty, in spite of nonsignificance based on operator discretion. (All had an FFR in between 0.85 to 0.90).

Six months follow up of renal function and control of blood pressure revealed better control in the FFR positive group P is less than. no significant difference between the intervened group and non-intervened groups. (Po=0.41)

**Conclusion:** FFR may not reliably identify the significance of renal artery stenosis by parameters derived from coronary studies. However, it does seem to predict the short term clinical outcome.

### A comparative study of the outcome of door to balloon time in working and non working hours for PAMI

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**Methods:** 121 consecutive patients who opted for PAMI for acute ST elevation myocardial infarction, admitted to Fortis hospital Cunningham road from 1-04-2014 to 31-07-2014 were included in the analysis. Off working hours was defined as PAMI done from 8 pm to 8am & on Sundays and holidays.

**Results:** Total 121 patients of which 64 of them underwent PAMI during working hours, 57 of them underwent PAMI during non working hours. For 8 patients of the total STEMI's were planned for interval CABG; 3 patients had normal coronaries, 3 patients expired (in hospital). 2 patients had cerebro vascular accidents (1 readmission). The fluroscopy time for PAMI in working hours was 13min45sec; non working hours was 13min06sec. The door to balloon time was 86min in working hours and 87min in non working hours.

**Conclusion:** In our study done so far both working and non working hours PAMI have similar outcomes and with similar door to balloon & fluroscopy time.

### Discrepancy in assessment of successful balloon mitral valvotomy (BMV) in patient with AF – Dissociation of LA mean pressure over MVO and mean gradient

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**Background:** The success of BMV is assessed traditionally by doubling of mitral valve area and by reduction of mean mitral valve gradient >50% from baseline value. In patient with AF these parameters are variable. It is frequently observed LA mean pressure fails to fall in spite of improving MVO and falling mitral gradient. In this context we analysed the LA mean pressure in patients who have successful BMV by standard definition.

**Methods:** 30 patients with symptomatic severe mitral stenosis were subject of the study. They underwent balloon mitral valvotomy as per standard protocol. All patient underwent measurement of MVOA by planimetry, MVG, LA mean pressure pre and post BMV.

**Results:** In patients with SR the post BMV mean MVOA was 1.9 cm<sup>2</sup> (range1.2-2.2cm<sup>2</sup>) mean MVG 5mmhg (range3-12mmhg), LA mean pressure 11.5mmhg (range 7-16 mm Hg). All 24 patients who are in SR the fall in LA mean pressure by 50%. In patients with AF only one patient (5/6) had 50% fall of LA mean pressure and the remaining 5 patients does not show 50% fall of LA mean pressure. Grade I MR was observed in 6 patients (6/30) were did not have significant influence on LA pressure.

**Conclusion:** LA mean pressure decreased promptly and significantly following successful BMV in patient with sinus rhythm. However in patient with AF LA mean pressure was persistently high in spite of substantial gain in MVOA and fall in mean MVG.