SYNTAX score subgroups demonstrated numerically higher MACE rates in patients with PES compared to EES (15.3% vs. 5.1%) and (30.0% vs. 15.4%) respectively.

Patients with low and intermediate SYNTAX scores had similar TLF outcomes at 1 year. However, the high SYNTAX score group had a significantly higher rate of TLF in the PES group (27.5% vs. 10.3%, p=0.01).

Cardiac death was higher in patients with an intermediate SYNTAX score in PES patients (6.8% vs.0.0%, p=0.04) as was TVMI (8.5% vs. 0.0%, p=0.02).

Conclusion: Unprotected LM stenting with EES is feasible, safe and more effective in the mid term, than with PES with a reduction in MACE, TLF and cardiac death at one year.

Table 1 – One- year follow-up results

	EES	PES	*P*
All cause death	2.9%	6.4%	0.13
Cardiac death	1.2%	4.7%	0.05
Target vessel myocardial infarction	4.1%	8.7%	0.08
Clinically driven target-lesion revascularization	2.9%	5.8%	0.19
Clinically indicated target vessel revascularization	7.0%	13.4%	0.05
Target lesion failure	6.4%	14.0%	0.02
MACE	8.1%	16.3%	0.02
Device-oriented composite *Cardiac death+MI-TLR*	6.4%	16.3%	0.004
Stent thrombosis	1.2%	6.4%	0.01

023

HIV-infected status is associated with increased recurrence of acute coronary syndrome. Results of long term follow up of the PACS-HIV study

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Objectives: The PACS-HIV study is designed to evaluate the 3-year prognosis of acute coronary syndrome (ACS) in HIV-infected patients (HIV+) as compared to HIV-uninfected patients (HIV-) in a prospective observational study. We aim to present the long term 3-year follow-up.

Methods: We enrolled consecutively 103 HIV-infected and 195 HIV-uninfected patients with a first episode of ACS matched for age (± 5 years), sex, and type of ACS. The primary endpoint was the rate of major adverse cardiac and cerebral events (MACCE), comprising cardiac death, recurrent ACS, recurrent coronary revascularization, and stroke.

Results: The mean age of the cohort was 49.0 ± 9.4 years and 94% were men. At baseline, coronary risk factors were well balanced and angiographic features were not different between both groups. MACCE at 3-year are depicted in Table. The rate of occurrence of first MACCE at 36-months was similar in both groups (uivariate hazard ratio [HR]=1.4, 95% CI, 0.7-2.6). However, recurrent ACS was more frequent in HIV+ group as compared with HIV- group (univariate HR=3.4, 95% CI, 1.3-8.8). Stratified multivariate Cox

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model showed that the only factor associated with the recurrence of ACS was HIV status with HR 7.86 for HIV+ versus HIV- (95% CI, 1.2-50.6, p= 0.03).

Conclusion: HIV-infected patients had higher recurrence of ACS despite similar coronary risk factors, clinical, and angiographic features at baseline of a first episode of ACS as compared to HIV-uninfected patients. Specific secondary prevention may be warranted to alleviate this risk.

Table – MACCE at 3-year

	HIV+ (n=103)	HIV– (n=195)	Univariate Hazard ratio [95% CI]*
Major adverse cardiac events	17 (16.8†)	29 (15.1†)	1.4 [0.7-2.6]
Cardiovascular death	2 (3.0†)	3 (1.6†)	2.0 [0.4-9.9]
Recurrent ACS	12 (11.9†)	11 (5.8†)	3.4 [1.3-8.8]
Recurrent coronary revascularization	12 (11.8†)	24 (12.6†)	1.1 [0.5-2.2]
Target lesion revascularization	8 (7.8†)	17 (9.0†)	0.9 [0.4-2.1]
Target vessel revascularization	11 (10.8†)	20 (10.5†)	1.1 [0.5-2.3]

024

Long term prognosis value of heart rate in coronary artery disease

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Purpose: Our aim was to assess the long term prognosis value of resting HR in a contemporary large cohort of subjects with known CAD.

Methods: Among 834 consecutive male pts hospitalized in 2001-2004 for coronary artery disease, HR was measured in 778 pts. The median follow-up was 7.17 years. Total mortality was predicted with a Cox proportional hazard model

Results: Mean age (SD) was 60.2 (8.1), 144 pts (18.4%) were diabetic, mean glycaemia was 5.9 mmol/l (2.1), 155 pts (19.8%) were smokers, mean blood pressure was 139 (20) / 84 (11) mmHg. Mean HDL cholesterol was 43 mg/dl (11), mean LDL cholesterol124 mg/dl (39) and median triglycerides were 147 mg/dl IQR [109-197]. Mean Cockcroft-Gault creatinine clearance was 87 ml/min and 11 pts (1.4%) had a severe chronic renal failure (lower than 30 ml/min). Mean left ventricular ejection fraction was 0.53 (0.13). 88.5% were on antiplatelet therapy, 75.2% on beta-blocker, 66% on statin therapy and 54.8% on ACE inhibitors or ARB.

40.5% of pts had HR < 60 bpm, 32% HR between 60 and 69 bpm and 27.5% had HR ≥70 bpm. The cumulative seven-year total mortality rate was 17.8%. In the HR < 60 bpm group, mortality rate was 11.1%, whereas it was 17.3% in the group with HR - 60 bpm and < 70 bpm and 28.5% in the HR ≥70 bpm group (p<.001).

We performed a multivariate analysis adjusted for age, diabetes, tobacco consumption (none; ≤40 pack-years; > 40 pack-years), left ventricular ejection fraction (>0.5; ≤0.5 and > 0.35; ≤0.35), duration of CAD, ankle-brachial index (> 0.9; ≤0.9 and > 0.6; ≤0.6), history of chronic obstructive pulmonary disease or stroke, statin therapy and coronary revascularization. For every 5 bpm increase in resting heart rate, there was a significant 11% increase in all-cause death (95% CI [4%; 18%] p=0.002).

Conclusion: HR is a strong and independent long term predictor factor of all-cause death in CAD. A close control of HR should be promoted to improve long term prognosis in coronary pts.