

obtained in 587/610 (96%) of them. At the end of FU, 211 (36%) pts were on single APLT (SAPLT) and 376 (64%) on DAPLT. Bleeding complications were defined according to PLATO and TIMI definitions

Results: The incidence of bleeding was higher in DAPLT pts (14.6% vs 3.8%, $p<0.0001$). Minor bleeding according to PLATO occurred in 1.9% of pts on SAPLT and 11.7% on DAPLT ($p<0.0001$) and according to TIMI in 2.4% vs 13.6% respectively ($p<0.0001$). Major bleeding according to PLATO presented the 1.9% of pts on SAPLT and 2.9% on DAPLT; according to TIMI the incidence of major bleeding was 1.4% and 1.1% respectively (p :NS for both PLATO and TIMI definitions). The incidence of cardiovascular adverse events was similar between pts with bleeding as compared with those without bleeding. In a multivariable analysis, smoking was an independent predictor for overall as well as major bleeding according to PLATO (HR 6.2, 95% CI 1.2-30.4, $p=0.024$), whereas DAPLT was an independent predictor for overall and minor bleeding (HR 6.2, 95% CI 2.2-17.3, $p<0.0001$)

Conclusion: Long-term DAPLT in diabetic patients treated with DES is associated with higher risk of overall and minor but not major bleeding. Smoking was an independent predictor for overall bleeding and major bleeding according to PLATO definitions

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Contemporary predictors of success in PCI of chronic total occlusions

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Background: Percutaneous Coronary Intervention (PCI) of Chronic Total Occlusions (CTO) remains relatively infrequent partly due to the uncertainty and paucity of data on the likelihood of successful PCI of these lesions. We sought to examine factors that may predict successful PCI of CTO in order to improve patient selection and optimisation of conditions for success.

Results: Of 1,509 consecutive PCI of CTO in our institution performed between 2004 and 2011, the median age was 63 and 86% were male. The success rate of PCI of CTO was 71%. Significant univariate correlations to successful PCI were operator experience ($r=0.08$, $p=0.002$), and tapered morphology ($r=0.1$, $p=0.0001$), while factors that contributed to failure were age ($r=-0.06$, $p=0.02$), lesion length ($r=-0.2$, $p<0.0001$), no visible stump ($r=-0.08$, $p=0.001$), calcification ($r=-0.15$, $p=0.04$), any tortuosity ($r=-0.05$, $p=0.046$), previous MI ($r=-0.1$, $p=0.0001$) and previous CABG ($r=-0.12$, $p<0.001$). Table 1 shows the significant predictors in terms of their odds ratios of successful PCI of CTO in a multivariable logistic model which also adjusted for age, sex, radial access, femoral access, operator experience, previous attempts, lesion length, stump visibility, calcification, tortuosity and previous CABG. Radial access was as good as femoral access in terms of successful PCI of CTO (OR 1.1, $p=0.7$ vs OR 1.0, $p=0.8$).

Conclusions: In this contemporary series, age, lesion length, operator experience, stump visibility, tapered morphology, calcification, tortuosity, previous MI and previous CABG affect successful PCI of CTO.

Table 1 – Selected significant predictors from multivariable model

	OR or successful PCI of CTO	95% CI	P value
Age (per yr increase)	0.98	0.98, 0.99	0.03
Lesion length (per 1 mm increase)	0.97	0.97, 0.98	<0.001
Operator experience (per 50 cases increase)	1.13	1.06, 1.19	<0.001
Stump visible	1.51	1.12, 2.06	0.008
Tapered morphology	1.36	1.03, 1.78	<0.001
Calcification	0.74	0.65, 0.84	<0.001
Any tortuosity	0.72	0.53, 0.98	0.04
Previous MI	0.67	0.50, 0.88	0.005
Previous CABG	0.44	0.29, 0.68	<0.001

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Thirty months outcomes after PCI of unprotected left main coronary artery according to the SYNTAX score.

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Aims: To assess middle term outcomes according to SYNTAX score and rates of delayed surgical/bleeding events after unprotected left main (LM) coronary artery (ULMCA) PCI in an unselected patients population.

Methods: Consecutive patients treated by PCI for ULMCA were included among a single center 3508 PCI database within 36 months. Syntax scores were calculated, post discharge extracardiac surgery or hemorrhage were recorded during follow-up as clinical outcomes (Death, TVR, MACCE=cardiovascular death+MI+stroke+TLR).

Results: 102 (3.6%) patients underwent PCI of the LM, including 21 protected LM. Among the 81 patients with PCI of ULMCA, mean age was 65 ± 13 , 27% had urgent PCI for AMI or cardiogenic shock, 61% had DES.

SYNTAX score was 28 ± 14 in mean and ≤ 22 in 30 (37%), 23 to 32 in 22 (27%) and ≥ 33 in 29 (36%) patients.

At 30 ± 11 months follow up (98% of the patients), death occurred in 24 patients (30%), TVR in 16 (20%) and MACCE in 35 (43%). Clinical events according to the SYNTAX score are shown in figure. No cardiovascular death occurred in patients with syntax ≤ 22 . MACCE rates were significantly lower when DES were used (24% vs. 64%, $p<0.05$) and in case of non-urgent PCI (36% vs. 71%, $p<0.05$).

During follow-up, 20 (25%) and 12 (15%) patients underwent unplanned extracardiac surgery and/or hemorrhage, leading to antiplatelet withdrawal in 31% of the cases.

Conclusions: In unselected patients treated by PCI of ULMCA with Syntax score ≤ 22 , outcomes were found to be excellent with no cardiovascular death observed at 30 months. DES and non-urgent PCI were associated with a better prognosis. One patient out of three underwent unplanned extracardiac surgery or hemorrhage during follow up.

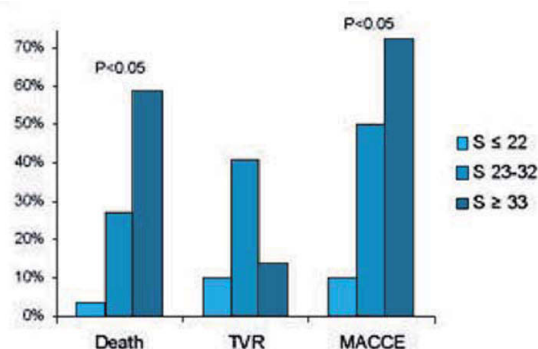


Figure: 30-months outcomes according to SYNTAX score

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New reference levels for radiation doses to patients undergoing coronary angiography and coronary percutaneous interventions: the RAY ACT study

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