defined as reduction by at least 50% of the ST elevation in the lead with the maximum ST elevation. Holter Monitoring for the first 24 hour was done and arrhythmias were documented.

Results: Arrhythmias occurred more frequently with successful reperfusion (82% versus 63%) (p= 0.04). The occurrence of AIVR with successful reperfusion was highly significant (p= 0.015) Though AIVR was found to have low sensitivity (47%) and specificity (77%) as a predictor of successful thrombolysis, early AIVR was much more common (p= 0.019) with successful thrombolysis. Successful thrombolysis did not change the incidence of sustained ventricular tachycardia, frequent PVC, AV blocks and A fib.

Conclusions: Successful thrombolysis with STK causes more frequent AIVR. Early AIVR is highly predictive for successful thrombolysis. Serious arrhythmias are unaffected by streptokinase. Pre-hospital administration of STK should be safe, thus saving critical time in acute MI. This is especially relevant in large parts of India.

Table 1Arrhythmias in Group A (Successful Thrombolyis) and Group B (Failed Thrombolysis)

Arrhythmia	Group A	Group B	P Value
AIVR	24 (47%)	14 (23%)	0.015
Frequent VPC's	16 (31%)	12 (20%)	0.248
Sustained VT	2 (3.9%)	9 (15%)	0.104
Ventricular Fibrillation	3 (5.9%)	3 (5.0%)	1.00
Atrial Fibrillation	2 (3.9%)	2 (3.3%)	1.00
Sinus Pauses	2 (3.9)	2 (3.3%)	1.00
AV Blocks	4 (7.8%)	2 (3.3%)	0.415

Transfer of patients for primary angioplasty from non PCI capable sattelite centres - A single operator experience

Asha Mahilmaran

Apollo Hospitals, Chennai, India

Aim and objective: To assess the safety and efficacy of primary PCI by transfer from sattelite centres to PCI capable tertiary centre.

Method: A total of 57 cases of STEMI shifted from 2 Non PCI capable satellite centres located 3 and 12 km away from the tertiary centre during a period of 18 months Jan 2013 to July 2014 were included in the study. NSTEMI, patients given lytic tyherapy, presenting with MI beyond 24 hours were excluded. Study cohort included 42 males, 15 females.The age range of pts was 27-81 yrs. All patients were given loading dose of 600 mg clopidogrel/180 mg ticagrelor/60 mg prasugrel, aspirin 325 mg, atorvastatin 80mg, intravenous enoxaparin 0.3 mg, preparation done, stabilzed haemodynamically and transported by fully supported ambulance.

Results: The location of MI was anterior in 29 cases, inferior in 20 cases, lateral in 6 cases. The door to balloon time was 40-150 minutes, average of 102 mts. 7 pts presented with cardiogenic shock, 6 pts with pulmonary edema. IABP support was used in 3 pateints, ventilatory support in 3, thromboaspiration in 10 pts. Survival was 56/57 pts. 1 pt with DM, CKD, extensive AWMI, CHB, cardiogenic shock died during procedure, 2 pts with LM disease, 1 pt with failed PCI sent for CABG. PCI was successful in 53/55 pts. Radial access was used in 10 pts. All pts underwent single culprit vessel angioplasty. One pt with double MI underwent sequential RCA, LAD PPCI. 30 day mortality of the entire cohort was 1.75% with a survival rate of 98.2%.

Conclusion: It is safe and rewarding to transfer patients PPCI from satellite centres.

Outcomes of Primary PCI comparing fEmoral versus RAdial arterial access in STEMI – OPERA study

Pillai Siju Balakrishna, Sunitha Vishwanathan, A. George Koshy, Prabha Nini Gupta, K. Sivaprasad

Government Medical College, Trivandrum, Kerala, India

Background: Effective reperfusion in STEMI can be achieved by either fibrinolytic therapy or primary percutaneous coronary intervention (PCI) without antecedent fibrinolysis (also generally known as primary angioplasty. Primary PCI can be done either via the femoral access or the arterial access. Radial arterial access is reported to have better outcomes as compared to femoral arterial access.

Methods: This is a retrospective intermediate term follow up study of consecutive patients with acute myocardial infarction admitted to MCH Trivandrum and underwent Primary PCI from October 2012 to April 2014.

Results: A total of 667 patients were admitted with a diagnosis of STEMI. The mean age was 57.17 ±11.22 years. Males were predominant, accounting for almost 85.6 % of the study population. CAD Anterior wall Myocardial infarction (48.42 %) and Inferior wall myocardial infarction (51.58 %) were equally represented in the study cohort (NS). Of the total cohort of STEMI population, primary PCI was performed via the femoral arterial access in 53.8 % and via radial access in 46.2 %. ST resolution was slightly higher in the femoral group, but was not statistically significant [radial 49.33 ± 35.8 % vs. femoral 54.15 ± 34.51 %. p=0.079].The amount of contrast volume used for the Primary PCI was slightly higher in the femoral group, but was not statistically significant [radial 163.47 ± 57.7 ml vs. femoral 167.03 ± 76.11 ml; p=0.51]. The mean fluoroscopic time required for completion of the Primary PCI was slightly higher for the radial group, but was not statistically significant [radial 10.82 ± 6.42 min vs. femoral 10.61 ± 10.03 min; p= 0.75] There were 4 (1.1 %) femoral pseudo aneurysms in the femoral group & 1 (0.2 %) femoral Arterio – venous fistula in the femoral group. The incidence of in hospital death was higher in the femoral arterial group [radial 1(0.3%) vs. femoral 14(3%); p=0.002], this was a statistically significant finding. The incidence of stent thrombosis was slightly higher in the radial arterial access group but even though the difference was not statistically significant. [Radial 6(1.9%) vs. femoral 4(1.1%), p=0.5].

Conclusions: In this study, femoral arterial access in the setting of a Primary PCI was associated with a higher in hospital mortality. None of the individual primary end points in itself were statistically significant to explain the increased in hospital mortality in the Femoral group. This observation could probably be due to the selection bias towards Femoral arterial access in the unstable group of patients. In experienced hands, the Radial approach should be the favored route for primary PCI.