9,412 patients (documented about route of access and procedure strategy) were evaluated (STEMI, n=6,798 and NSTEMI, n=2,614).

Results: Based on baseline characteristics, the patients in TFI group (n=7,607) were older, more over-weighted, female patients, recusations before arrival, STEMI patients, worse Killip class and MR grade. TFI group (n=1,805) had lower in-hospital morbidities, especially major bleedings and puncture site complications, ICU admission, inotropics apply, all cause mortality and MACE at discharge and 1 month later. The post-TIMI flow and success rate of PCI were not significantly different between two groups, however. In multivariate analysis, type of myocardial infarction, inotropic apply, ICU admission and all cause mortality were related to the route of access. In-hospital morbidities and MACE at 1 month were not related to the route of access.

Conclusions: Patients of TFI group had showed less STEMI patients and lower all cause mortality. The in-hospital morbidities and 1 month MACE of TFI were not different from those of TFI, however. It requires prospective and randomized controlled trials to assess clinical efficacy and in-hospital morbidities related to route of access for interventional procedure adequately.

TCT-461

Abstract Withdrawn

TCT-462

Invasive Strategies And Outcomes For Non-ST-segment Elevation Acute Coronary Syndromes: A Twelve-year Experience From SWEDHEART

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Background: Despite the recommendations of a routine invasive strategy (RIS) over a selective invasive strategy (SIS) in the most recent and previous clinical practice guidelines for non-ST-segment elevation acute coronary syndrome (NSTE-ACS), data on the implementation of these treatment strategies in clinical practice over a longer time period is currently not available.

Methods: In SWEDHEART, baseline, procedural characteristics and outcomes are recorded of all patients undergoing PCI. The RIS was retrospectively defined as coronary angiography (CAG) and subsequent revascularization <3 days after admission. The SIS was defined as CAG later than 3 days or none at all. Event rates were estimated with the Kaplan-Meier method.

Results: Between 1996 and 2007, 204,092 consecutive NSTE-ACS patients were recorded in SWEDHEART. The use of a RIS increased from 3.8% in 1996-1998 to 37.4% in 2005-2007. The largest absolute increase was observed in low-risk patients, as recorded in SWEDEHEART. The use of a RIS increased from 3.8% in 1996-1998 to 37.4% in 2005-2007. The largest absolute increase was observed in low-risk patients, as recorded in SWEDEHEART. The use of the SIS decreased from 96.2% in 1996-1998 to 62.5% in 2005-2007. In the total population, there was a gradual decrease in three-year all-cause mortality, from 29.1% in 1996-1998 to 23.9% in 2005-2007. This was mainly observed in patients undergoing a RIS.

Conclusions: In conclusion, there has been an increase in the use of a RIS in NSTE-ACS patients over the course of 12 years in Sweden. Absolute increase was mainly observed in low-risk patients, while a similar relative increase was observed in all risk groups. There was a decrease in 3-year mortality over the time course, but this was not observed in SIS patients.

TCT-463

In-hospital Mortality Following Primary Angioplasty in the Setting of Cardiac Arrest is High and Varies Depending on Patient Location at the Time of Arrest: A UK Registry Database Study

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Background: Despite advances in therapeutic strategies, cardiovascular disease is the leading cause of death particularly among high-risk patients including those that present with cardiogenic shock and those that sustain cardiac arrest (CA). The mortality rate among patients undergoing primary angioplasty (PPCI) in the setting of CA and whether the location where the patient sustains cardiac arrest influences the outcome is not known in the contemporary era. Aims: The aim of this study is to describe the patient population accepted for PPCI sustaining CA to determine in-hospital (I/H) mortality and to determine whether the location where the patient experiences CA influences outcome.

Methods: Data were collected prospectively on all patients undergoing PPCI for ST elevation myocardial infarction in the setting of CA to a large UK tertiary cardiac centre between January 2006 and October 2011. All patients sustaining CA either pre-hospital (before and after the arrival of ambulance), during PPCI, or at any stage during hospitalisation were recorded.

Results: In total, 335 patients (mean age 62.5 years) sustained CA during the study period. Of these, 317 (94.6%) had PPCI performed. 53 (15.8%) patients sustained CA prior to ambulance arrival, the remainder occurred [28% (4%)] either after the ambulance arrived or in-hospital (emergency room, medical ward or catheter lab). There were more patients with cardiogenic shock who sustained CA before ambulance arrival (38.5%). The I/H mortality was 21.2% in the overall CA patients. Those sustaining CA before ambulance arrival experienced the highest mortality 32.1% compared to those (19.1%) that had CA after ambulance arrival, in-hospital and in the catheter lab (Odds Ratio 1.99, 95% Confidence Interval 1.04-3.8). Furthermore, patients experiencing asystole or electromechanical dissociation were associated with increased I/H mortality compared to those experiencing ventricular arrhythmias (OR 2.83, 95% CI 1.56-5.14).

Conclusions: The I/H mortality remains high among patients undergoing PPCI in the setting of CA. The I/H mortality is particularly high among those that arrest prior to ambulance arrival.

TCT-464

The Killip Classification is Still Useful in Current Practice? An analysis of 4342 patients in the Regional Acute Myocardial Infarction Registry of Brittany (ORBI).

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Background: The use of simple clinical criteria are there still of interest in our daily practice with the advent of new markers of severity? This is the question which we wanted to answer by revisiting the Killip classification.

Methods: We analyzed data collected between June 06 and October 11 in the “Observatoire Régional Bréton sur l’Infarctus (ORBI)”, a prospective registry of all patients admitted to an interventional cardiology centre of Brittany in the acute phase of a STEMI, within 24 h of symptoms onset. Main clinical data are presented and intra hospital outcome was compared regarding of the Killip class determined at admission.

Results: Among 4342 patients included in the ORBI registry, Killip 1, 2, 3 and 4 respectively represented 65 (1.5%), 3582 (88%), 281 (6.4%), 94 (2.2%) and 146 (3.4%) patients. Main clinical data are summarized in table 1. There is a significant relation between the Killip class and the intra hospital mortality (respectively 104 (2.7%), 27 (9.6%), 18 (19.1%), and 73 (50%) for Killip 1, 2, 3 and 4, p<0.001), the hospital length of stay (6.6±3, 8.0±2.5, 9.1±6, and 7.6±7, p<0.05) and the left ventricular systolic ejection fraction at discharge (51.3±10, 44.1±11, 41.7±12, and 38.4±14, p<0.05).