Table 1. Evaluating added predictive ability of adding CKD-EPI equations to MDRD for prediction of mortality using reclassification index.

<table>
<thead>
<tr>
<th>Method</th>
<th>HR 0.978 [95% CI 0.959 to 0.997], p = 0.025 Reclassification analyses showed that all CKD-EPI equations more accurately categorized the risk for mortality than MDRD (Table 2).</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDRD + CKD-EPI creatinine</td>
<td>5.2% &lt; 0.001 17% 0.014 14% 3%</td>
</tr>
<tr>
<td>MDRD + CKD-EPI cystatin C</td>
<td>7.7% 0.003 18% 0.051 16% 0%</td>
</tr>
<tr>
<td>MDRD + CKD-EPI creatinine–</td>
<td>8.5% 0.003 19% 0.037 19% 0%</td>
</tr>
</tbody>
</table>

Conclusion: In patients with non-ST elevation ACS, CKD-EPI equations based provide more accurate risk stratification than MDRD for the prediction of mortality.

P2259 | BEDSIDE
Routine invasive strategy is of most benefit in trials that did not specify positive cardiac biomarker status as an inclusion criterion: a meta-analysis

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Purpose: We further explored the hypothesis of fewer cardiac deaths among Unstable Angina and Non-ST-Elevation Myocardial Infarction (UA/NSTEMI) patients undergoing early angiography, attempting to address previous concerns on baseline risk of patients as assessed by troponin status.

Methods: Only randomized controlled clinical trials reporting data on cardiac biomarkers were considered for inclusion in this meta-analysis. Routine invasive and selective invasive strategies were compared as follows: analysis 1: trials only recruiting patients with positive cardiac biomarkers (NSTEMI) versus those that recruited participants with positive and negative cardiac biomarkers as an inclusion criterion (UA/NSTEMI), regardless of stents use; analysis 2: trials selected with stents deplayed during procedures. The primary end-points were mortality, recurrent non fatal MI and their combination.

Results: For analysis 1, a total of 8 trials (10,411 patients) were eligible for our study: 3 with NSTEMI (VINO, VANWISH and ICTUS) and 5 with UA/NSTEMI (TIMI IIIb, MATE, FRISC II, TACTIS-TIMI 18 and RITA 3). For analysis 2, three of the eight selected trials (MATE, TIMI-3B and VANWISH) were excluded because they were undertaken in the pre-stent era. Duration of the follow-up periods ranged from 6 to 24 months. In the period of time from randomization to the end of follow-up, the use of routine invasive strategy was associated with a significant reduction for the composite ischemic events with 21% lower odds (RR 0.79; CI, 0.70-0.90) in UA/NSTEMI. In contrast, there was no benefit of the use of such strategy (RR 1.19; CI, 1.03-1.38) in NSTEMI. The observed effects were consistent among most evaluated trials except for the case of MATE in UA/NSTEMI and VINO in NSTEMI. Regarding the period of time from randomization to discharge, a routine invasive strategy was associated with significantly higher odds of the endpoint in both UA/NSTEMI (RR 1.28; CI, 1.11-1.46) and NSTEMI (RR 1.85; CI, 1.49-2.29). Changing the methods for analysis from all randomized studies to studies that were undertaken in the post-stent era (analysis 2) did not alter the interpretation of the data.

Conclusions: Contrary to expectations, a routine invasive strategy is of most benefit in trials recruiting a large number of UA patients, whereas it cannot be proven to reduce deaths or nonfatal myocardial infarction in NSTEMI patients. Potential clinical benefits from PCI do not seem to favorably affect the overall prognosis of the index myocardial infarction.

P2260 | BEDSIDE
Genetic polymorphisms on chromosome 9p21 and 6p24 and long-term follow-up after acute coronary syndrome

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Purpose: Several single nucleotide polymorphisms (SNPs) were found in genome-wide studies to correlate with coronary artery disease. So far little is known about the prognostic value of those genetic markers. We tested the prognostic value of rs12526453 (SNP located in an intron of phophastase and actin regulator 1 (PHACTR1) on chromosome 9p21) and rs10757278 (from 9p21 locus) in patients (pts) with acute coronary syndrome (ACS).

Methods: Consecutive pts with ACS (myocardial infarction or unstable angina) were included in the registry in the years 2008-2010. The endpoint was all-cause death. Median follow up was 1252 (IQR 1098-1401) days. All pts were genotyped for rs12526453 and rs10757278.

Results: 551 consecutive pts were included (493 were treated with primary angioplasty). Major allele frequency was 0.49 for rs12526453 and 0.70 for rs10757278. During follow up 102 pts has died. In univariate Cox-regression analysis both polymorphisms were significantly linked with prognosis (HR (CI)): rs10757278: 0.67 (0.51-0.89), p<0.006 and rs12526453: 0.72 (0.55-0.92), p<0.021. In multivariate Cox-regression analysis only 9p21 was significantly linked with prognosis after ACS. The other factors significantly correlated with prognosis were: age, heart rate at admission, previous myocardial infarction and history of heart failure. Kaplan-Meyers curves for 9p21 are shown on the figure 1.

Figure 1

Conclusions: 9p21 polymorphism is linked with prognosis after myocardial infarction. Polymorphic allele seems to have protective effect.