ported within 7-days follow-up, only 2 patients in each group developed a mild hematoma on vascular access site. There was no difference in all-cause mortal-
ity rate between both groups at 1-year follow-up (0.23%, 1 patient vs. 1.21%, 7 patients, respectively; p=0.084).

Conclusions: Same-day discharge strategy after elective PCI is feasible and safe
in selected patients, with rates of complication and outcome similar to those ob-
tained with the overnight stay strategy. It may represent a helpful method to re-
duce costs and optimize hospital resource utilization.

P4790 | BEDSIDE
Bleeding and platelet P2Y12 receptor inhibition following
percutaneous coronary intervention for acute coronary syndrome
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Background: Suboptimal platelet P2Y12 receptor inhibition increases the risk of
thrombotic events, but the association between the degree of platelet inhibition
and bleeding is less well characterised.

Methods: We studied the impact of platelet P2Y12 receptor inhibition on bleeding
according to Bleeding Academic Research Consortium (BARC) class in 864 pa-
tients with acute coronary syndrome (ACS) enrolled in a prospective registry. Prior to PCI, patients underwent a VerifyNow test, which reports platelet
inhibition both as Platelet Reactivity Units (PRU) and %inhibition (PI).

Results: Over a median (IQR) follow-up of 59.8 (44.9) months there were 48
(5.6%) cases of bleeding: 29 (3.4%) in BARC class 2 to 5. The table shows dif-
cferences in baseline characteristics between patients with and without bleeding.
Most frequent bleeding types were epistaxis (46%), gastrointestinal tract (38%)
and arterial access site (13%). Multivariable regression identified PI (OR 1.02;
95% CI: 1.01 to 1.03), age (OR 1.05; 95% CI: 1.02 to 1.07) and length of time on
P2Y12 inhibitor (OR 1.39; 95% CI: 1.08 to 1.79) to be significantly associated with
bleeding. PRU was non-significantly negatively associated with bleeding.

After adjustment for baseline and procedural characteristics, BARC 2 to 5 bleed-
ing was independently associated with death (OR 4.46; 95% CI: 1.57 to 12.68; p =
0.003).

Baseline characteristics
Characteristic No bleeding Bleeding Univariate OR, P value
Mean (SD) age, years 61.8 (11.3) 67.8 (11.8) 1.05, 1.02 to 1.09 0.003
Female 156 (24.5%) 20 (41.7%) 2.26, 1.25 to 4.10 0.007
Median body mass
index (BMI) 28.1 (5.8) 26.7 (4.5) 0.95, 0.89 to 1.01 0.107
Prasugrel 42 (5.1%) 2 (4.2%) 0.80, 0.19 to 3.41 0.764
Thienopyridine treatment time (SD), years 1.27 (0.91) 1.64 (1.37) 1.37, 1.08 to 1.75 0.011
Femoral access 657 (80.5%) 39 (81.2%) 0.95, 0.45 to 2.01 0.900
Prasugrel (SD) 241 (91) 216 (10) 0.97, 0.94 to 1.0 (95% CI) 0.005

Conclusions: PI value is an independent predictor of bleeding while on treat-
ment with a P2Y12 receptor inhibitor following PCI for ACS. BARC 2 to 5 bleeding
is significantly associated with an increase in the risk of death.

P4791 | BEDSIDE
Revascularization strategy and long-term outcomes in patients
with a first episode of high-risk acute coronary syndrome
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Aims: To evaluate in patients (p) admitted with a first high-risk ACS (HRACS)
long-term outcomes according to revascularization (Rev) strategy.

Methods: Retrospective study that included 415 consecutive patients admitted
for first episode of HRACS and had significant stenosis in coronary angiography
over a period of 3 years. Strategies of Rev were classified as complete percuta-
neous (CPRev), complete surgery (CSRev) or incomplete percutaneous (IPRev).

Results: Outcomes were recorded as MACE (cardiovascular death, acute myocardial
infarction and non-fatal stroke) and No-MACE (readmission for angina or heart fail-
ure, new revascularization and no cardiovascular death). The sum of MACE and
No-MACE conformed total events (TEV).

Results: Age mean (SD) 65.6 (13.1) years with 71% males. 338p (82%) were
revascularized, and 77p (18%) not performed Rev for anatomical causes. In mu-
ltivessel coronary artery disease (CAD), patients with complete revascularization
had significantly less outcomes than patients with incomplete Rev (see events on
table). There were no significant differences in outcomes between one-vessel
and multivessel CAD patients with complete revascularization. There were no sig-
nificant statistical differences comparing both modes of complete Rev in patients
with multivessel CAD (long-term outcomes in patients with CPRev: 7.5% MACE
and 13.4% TEV; in patients with CSRev: 5.2% MACE and 10.5% TEV).

Completeness of Rev and events

<table>
<thead>
<tr>
<th>MACE (%)</th>
<th>TEV (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 months</td>
<td>24 months</td>
</tr>
<tr>
<td>Multivessel CAD</td>
<td></td>
</tr>
<tr>
<td>Incomplete Rev (n=107)</td>
<td>12.1</td>
</tr>
<tr>
<td>Complete Rev (n=86)</td>
<td>2.3</td>
</tr>
<tr>
<td>One-vessel CAD</td>
<td></td>
</tr>
<tr>
<td>Complete Rev (n=145)</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Conclusions: In patients with HRACS and multivessel CAD, the complete Rev
had better prognosis than incomplete in the short and long-term. The complete
Rev in one-vessel and multivessel diseases had a similar benefit. The mode of
complete Rev in multivessel disease showed a similar effect on long-term prog-
diagnosis.

P4792 | BEDSIDE
Long term prognosis of contrast-induced acute kidney injury in
patients with acute coronary syndrome and previously
normal kidney function
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Purpose: Contrast-induced acute kidney injury (CI-AKI) is a serious complica-
tion after percutaneous coronary intervention (PCI). CI-AKI has been associated
with high in-hospital mortality and poor long-term survival. Pre-existing renal in-
sufficiency is the strongest predictor for developing CI-AKI after PCI. However, in
acute coronary syndrome (ACS) patients with normal renal function, risk factors
for CI-AKI and its long term implications have not been well studied, and consti-
tues the aim of this study.

Methods: We performed a single-center observational study with prospective
follow-up of 477 consecutive patients (mean age 65.2±12, 92 women [19.3%])
admitted with ACS undergoing PCI and with preexisting normal renal function
(creatinine <1.3 mg/dl), from October 2007 to April 2011. All patients undergoing
PCI at our institution were prospectively followed a minimum of 12 months (mean
26.5±14.2 months). CI-AKI was defined as an increase in serum creatinine ≥ 0.5
mg/dl or ≥ 25 percent above baseline.

Results: Of the 477 patients, 33 (6.9%) developed CI-AKI despite having normal
baseline creatinine values. Two patients (0.4%) required dialysis. Patients who
developed CI-AKI had lower left ventricular ejection fraction (LVEF) (47.8±12.0
vs. 54.8±13.8, p <0.01) and a trend toward higher levels of C reactive protein (29.5±46 mg/dl
vs. 19.6±31.1 mg/dl; p =0.065). Cox regression analysis showed that age, LVEF,
lower Sorenberg value, cardiac shock and CI-AKI were significant predictors
of mortality (hazard ratio [HR] 2.5, 95% CI [1.03-6.1]; p =0.043). Survival analysis showed that
patients that developed CI-AKI had higher mortality at follow up (24% vs. 6.5%;
<0.01).

Conclusion: CI-AKI after PCI in ACS patients with normal renal function is not
uncommon and significantly impacts long term survival. Therefore renal function
should be monitored even in patients with an apparently low risk of developing
CI-AKI.
the association between C-Reactive Protein (CRP) levels following PCI and clinical outcome in patients at our tertiary referral centre.

**Methods:** All patients accepted for PPCI between September 2009 and November 2011 were eligible for inclusion. Patient data were obtained from Cardiac Services Database System (Phillips CVIS), and mortality data from the Summary Care Record (SCR) database. Patient characteristics and clinical outcomes were compared according to CRP groups: low (<10 mg/L), intermediate (10-50 mg/L), and high (>50 mg/L). Continuous variables were compared using one-way ANOVA. Categorical variables were compared using the chi-squared test. A p-value of <0.05 was taken to indicate statistical significance.

**Results:** 1299 of 1872 eligible patients had a recorded CRP and were analysed. Patients in the high CRP group were more likely to be female (32.6% vs. 23.1%, p = 0.024) and older (mean age 67.3±14.1 vs. 63.9±12.5 years, p=0.011). Other characteristics were similar across groups (hypertension, diabetes mellitus, previous MI, CABG). 30-day mortality was significantly higher in the high group compared to the low group (1.3% vs. 16.7%, p < 0.001), as was overall mortality (hazard ratio 1.8, 95% CI 1.3-2.8) during a mean follow-up period of 2.1 years (Figure 1).

**Conclusions:** Our large-cohort retrospective study suggests that elevated CRP at PPCI is associated with significantly higher long-term mortality. Further work is required on strategies to modify inflammatory response following STEMI and improve clinical outcomes following PCI.

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**P4794 | BEDSIDE Randomized prospective impact of cilostazol associated with arrhythmia after percutaneous coronary intervention**

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**Purpose:** Cilostazol, a phosphodiesterase III inhibitor, have been used for adjunctive dual anti-platelet therapy (DAT) after Percutaneous Coronary Intervention (PCI). The elevation of CAMP by cilostazol might lead to tachyarrhythmia. However, its clinical implications have never been investigated.

**Methods:** The pilot study included 174 patients undergoing elective PCI in a prospective and randomized design. Patients were allocated in a 1:1 ratio to the Triple Anti-platelet Therapy (TAT, cilostazol and DAT) or the DAT. At baseline and at 6-month, 24-h holter was measured. Primary end-points were heart rate (HR) and number of ventricular premature capture (VPC) and secondary end-points were numbers of non-sustained ventricular tachycardia (NS-VT), atrial premature capture (APC), and Supraventricular Tachycardia (SVT).

**Results:** 84 were allocated to the DAT group and the remaining 92 allocated to the TAT group after elective PCI. Clinical and 24-h holter baseline was similar between the 2 groups. However, after follow-up of 6-month, HR and number of VPC in the TAT group higher than those of DAT group (HR, 68.9 ± 9.3 bpm vs. 74.1 ± 11.7 bpm, p = 0.005 and VPC, 79.7 ± 20.1 vs. 510.8 ± 1618.8, p < 0.001). There were no significant differences in the numbers of NS-VT, APC, and SVT between the 2 groups.

**Conclusions:** TAT after PCI increased HR and number of VPC, compared with DAT. In patients with tachycardia and frequent VPC, the use of cilostazol, as an add-on to the DAT, should be more cautious.

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**P4795 | BEDSIDE Two years follow up of outcomes from transradial vs. transfemoral primary percutaneous coronary intervention for ST elevation myocardial infarction**


**Objective:** We have compared the impact of access strategy change on early and late two-year outcomes after primary percutaneous coronary intervention using trans-radial access (TRA) versus intervention by trans-femoral access (TFA).

**Background:** Adoption of TRA was recently proposed as potentially beneficial strategy to improve outcomes of PCI for STEMI patients.

**Methods:** We have studied 1808 consecutive patients which underwent TFA (n=646) and TFA (n=1162) intervention for STEMI at our institution between 2007 and 2010. This was all-comers study regardless patient acute clinical presentation of STEMI. We have compared the cardiac mortality and the MACE rates (composite of death, stroke, re MI and TVR) after two years of follow up.

**Results:** The majority of deaths occurred as early events in the first 30 days from STEMI. The major difference in early mortality rates was in favor of TRA strategy (5.2% or 60 deaths) compared TFA strategy (10.5% or 68 deaths) (OR 0.46; 95% CI [0.32-0.66], p = 0.001). TARA was also associated with significant 30 days MACE rate reduction (7.3% vs. 10.5%; HR 0.55; 95% CI [0.39-0.76], p = 0.001). Following the first year of follow up additional 1.7% and 1.0% of deaths occurred in both groups respectively. At two years follow up there were 93 deaths (8.0%) mortality rates in TRA group comparing to 90 deaths (13.9%) in TFA group (OR 0.60; 95% CI [0.40-0.89], p=0.001). The difference obtained in the first 30 days between the two accesses strategies have sustained with similar trends for mortality rates in the following two years. Two year MACE rates were in favor of TRA strategy (14.6% vs 22.1%; OR 0.56; 95% CI [0.43-0.78], p < 0.001). Cumulative survival curves were created to illustrate findings.

**Conclusions:** Our study confirmed that transradial access strategy for primary coronary intervention is associated with significant early and two years MACE rate reduction comparing to default transfemoral access strategy for primary coronary interventions in STEMI patients. TARA was associated with sustained mortality benefit after two years.

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**P4796 | BEDSIDE Contrast induced nephropathy: a new predictive model based on pre procedural glyceremia and glomerular filtration rate**

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**Aims:** The risk of contrast induced nephropathy (CIN) is predicted by the already proposed formula of the ratio of contrast volume to glomerular filtration rate (GFR). Recent data from literature underscore that the incidence of CIN is significantly influenced by admission glyceremia. Therefore, our aim was to identify a predictive model of CIN based on the quantity of contrast used during pPCI, known independent predictors of CIN, and pre procedural glyceremia.

**Methods and results:** 679 STEMI patients treated with primary PCI (pPCI) were enrolled in our prospective study. CIN was defined as an absolute serum creatinine increase ≥0.3 mg/dl after procedure. Admission hyperglycemia was defined as glucose levels >198 mg/dl. Medium volume of contrast (DV) we used ranged from...