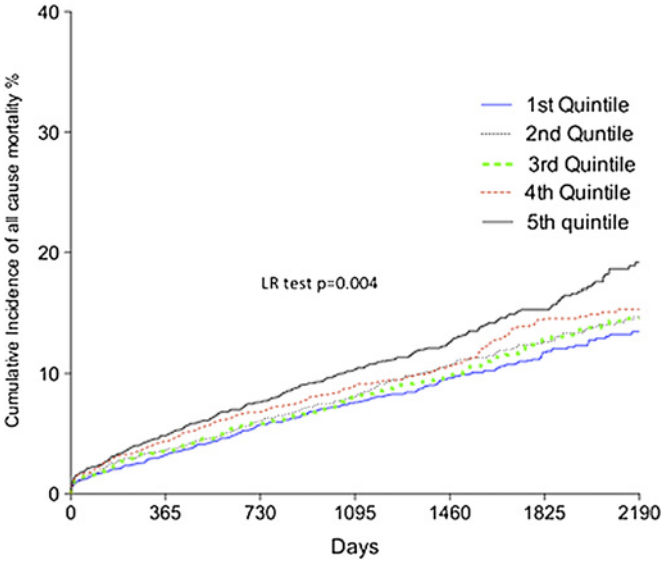
Abstract 045 Table 1 Baseline Characteristics according to socio-economic quintile (*p value <0.05)

	Quintile 1 (n=2760)	Quintile 2 (n=2750)	Quintile 3 (n=2752)	Quintile 4 (n=2758)	Quintile 5 (n=2750)	p Value
Age	65.99±11.0	65.39±11.6	63.51±11.8	62.5±12.4	61.52±12.0	p<0.0001
Gender (female)	688 (25%)	693 (25.2%)	733 (26.6%)	755 (27.4%)	701 (25.5%)	0.19
Ethnicity (Asian)	163 (8.8%)	370 (20.5%)	411 (22.2%)	795 (41.0%)	932 (46.6%)	p<0.0001
Previous Mi	602 (24.0%)	645 (25.7%)	667 (26.2%)	679 (26.7%)	705 (27.9%)	0.03
Previous CABG	191 (7.4%)	247 (9.7%)	186 (7.2%)	213 (8.2%)	226 (8.7%)	0.01
Previous PCI	464 (18.2%)	564 (22.1)	571 (22.1%)	645 (25.1%)	697 (27.0%)	p<0.0001
Current Smoker	340 (12.3%)	383 (13.9%)	576 (20.9%)	619 (22.4%)	690 (25.1%)	p<0.0001
Diabetes Mellitus	423 (15.8%)	584 (21.7%)	596 (22.1%)	867 (32.0%)	915 (33.8%)	p<0.0001
Chronic Renal Failure	43 (1.7%)	59 (2.4%)	62 (2.4%)	67 (2.7%)	101 (4.0%)	p<0.0001
MV disease	881 (31.9%)	963 (35.0%)	866 (31.5%)	945 (34.3)	915 (33.3%)	0.02
EF: Poor	48 (4.9%)	77 (7.5%)	50 (4.7%)	61 (5.4%)	87 (7.8%)	0.02

higher long-term mortality compared with quintile 1 (p=0.0004) (Abstract 045 figure 1). Age-adjusted Cox analysis showed an increase in the hazard of death for quintile 5 compared to quintile 1 (HR 1.18 (95% CIs 1.01 to 1.39) and this was maintained with multiple adjustment (HR 1.62 (95% CIs 1.13 to 2.33).



Abstract 045 Figure 1 Kaplan–Meier curve showing cumulative probability of all-cause mortality after PCI comparing quintiles of socioeconomic status.

Conclusions Lower SES is associated with higher long-term mortality following PCI and is independent of other recognised risk factors.

046 IMPACT OF INCOMPLETE REVASCULARISATION IN PATIENTS UNDERGOING PCI FOR UNPROTECTED LEFT MAIN STEM STENOSIS

doi:10.1136/heartjnl-2012-301877b.46

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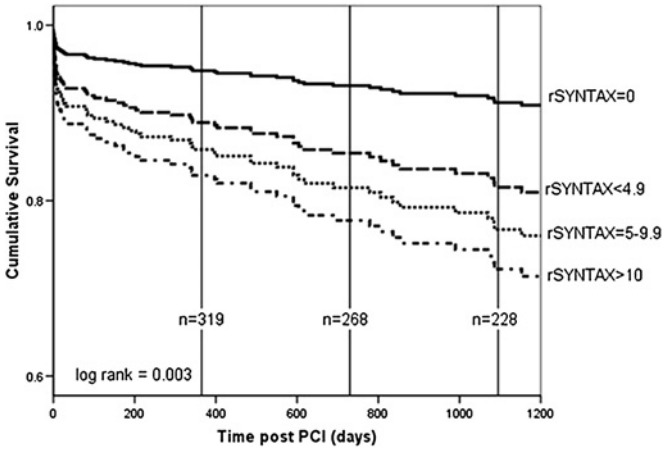
Aims To assess the impact of completeness of revascularisation upon outcome after PCI for unprotected left main stem (LMS) PCI in the "real world".

Methods and Results We studied 348 consecutive patients with LMS disease treated by PCI by a single operator with a policy of maximal feasible revascularisation between 2000 and 2011. The SYNTAX score was calculated before and after PCI (the residual SYNTAX (rSYNTAX) score) to gauge the completeness of revascularisation. The endpoint was mortality and repeat revascularisation. Average age was 68±10 years, baseline SYNTAX score was 33.6±15.2, 51% were non-elective, 10% were in cardiogenic shock and 49% were not surgical candidates. The LMS bifurcation was involved in 73% and 2.0±0.9 other vessels were diseased. Complete revascularisation was achieved in 49% and was associated with reduced mortality compared with incomplete, at 30 days, 1 year and 3 years (2.9% vs 13%, 5% vs 19%, 8% vs 26%; all p<0.0001). Median rSYNTAX score was 1 (0–11), 1-year survival for the lowest, middle and highest tertiles of rSYNTAX were 1.5%, 2.8% & 6.5% (p<0.0001), respectively. In multi-variate analysis, post procedure rSYNTAX score independently predicted outcome but pre-procedural SYNTAX score did not.

Conclusions In this single centre, "real world" series of patients with LMS disease treated by PCI, complete revascularisation was associated with superior survival vs incomplete. The rSYNTAX score, a novel index of completeness of revascularisation, independently predicted survival and the baseline SYNTAX score did not.



Abstract 046 Figure 1

047 TRENDS IN ACCESS SITE CHOICE AND PCI OUTCOMES: INSIGHTS FROM THE UK NATIONAL PCI DATASET

doi:10.1136/heartjnl-2012-301877b.47

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Heart: first published as 10.1136/heartjnl-2012-301877b.46 on 16 May 2012. Downloaded from http://heart.bmj.com/ on April 23, 2024 by guest. Protected by copyright.