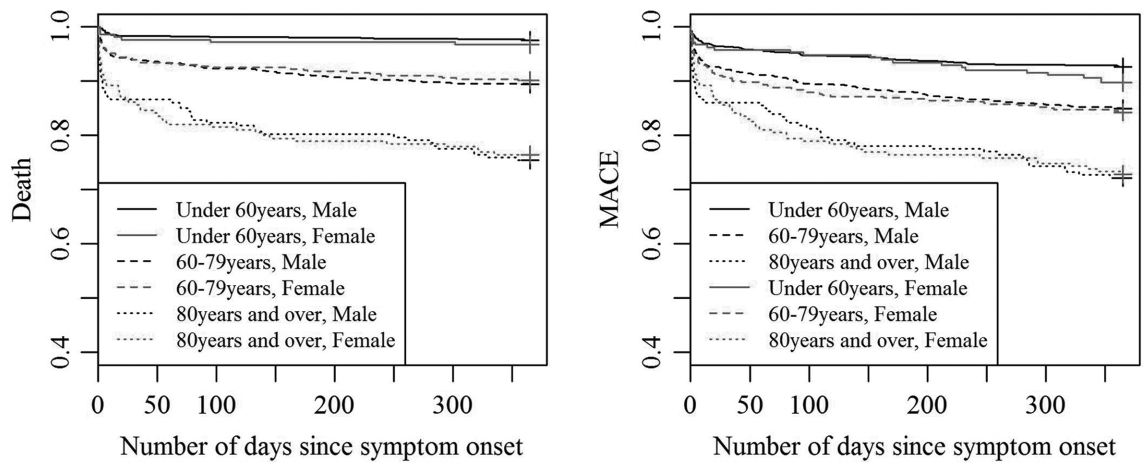

Abstract 26 Figure 2 Kaplan-Meier survival curves comparing age-adjusted mortality and MACE in females and males

mortality or MACE between genders (Table 2, Figure 2). Age directly correlated with total mortality and MACE. Comparison between the three age tertiles showed Group 2 was associated with a higher rate of death (HR 4.17, 95% CI 2.86–6.09) and MACE (HR 2.03, 95% CI 1.60–2.57) at 12m compared to Group 1. The highest rate of death (HR 10.53, 95% CI 7.07–15.67) and MACE (HR 3.93, 95% CI 2.99–5.17) was seen in Group 3.

Conclusion This large retrospective study has shown that whilst women appear to have significantly higher rates of death and MACE compared to men, when adjusted for age, gender was not associated with a statistically significant difference in outcomes. The difference in unadjusted outcomes may be due to the fact that women tend to present with STEMI at an older age than men. Therefore, the difference in outcomes is likely to be age-related rather than gender-related.

Abstract 26 Table 1 Total mortality and MACE rates in females and males

Gender	Number n	Death n (%)	MACE n (%)
Male	2223	175 (7.9)	276 (12.4)
Female	826	94 (11.4)	140 (16.9)
		p < 0.01	p < 0.01
		HR 1.48 (1.15–1.90)	HR 1.40 (1.14–1.72)

Abstract 26 Table 2 Age-adjusted mortality and MACE rates in females and males

Gender and Age	Number n	MACE n (%)	Death n (%)
Male <60	1060	78 (7.4)	26 (2.5)
Female <60	216	22 (10.2)	7 (3.2)
		p = 0.16	p = 0.51
		HR 1.40 (0.87–2.25)	HR 1.32 (0.58–3.06)
Male 60–79	976	146 (15.0)	103 (10.6)
Female 60–79	415	65 (15.7)	41 (9.9)
		p = 0.99	p = 0.53
		HR 1.00 (0.75–1.35)	HR 0.89 (0.62–1.28)
Male ≥80	187	52 (27.8)	46 (24.6)
Female ≥80	195	53 (27.2)	46 (23.6)
		p = 0.90	p = 0.83
		HR 0.98 (0.67–1.43)	HR 0.96 (0.64–1.44)

27 IMPACT OF CULPRIT VERSUS NON-CULPRIT ANGIOGRAPHY STRATEGY ON PRIMARY PCI DOOR TO BALLOON TIMES

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Background Guidelines for ST-segment elevation myocardial infarction (STEMI) recommend primary percutaneous coronary intervention (PPCI) within 90 min of arrival in a PCI-capable hospital. Some PCI operators perform diagnostic angiography of the non-culprit artery prior to intervention ('non-culprit' strategy) while others proceed directly to the presumed culprit vessel ('culprit' strategy) reserving imaging of the non-culprit vessel until after the PCI. We evaluated the 'time cost' of each approach and their impact upon door to balloon times (D2B).

Methods All consecutive patients presenting with STEMI to a regional heart attack centre between April 2014 and March 2015 (n = 630) were included. The time from the first angiogram acquisition (culprit or non-culprit vessel) to device use (thrombectomy catheter, balloon or stent) was recorded for each strategy. Overall D2B times were analysed.

Results A culprit strategy was followed in 69/630 and a non-culprit approach in 561/630. The mean time from first image to device use was 15 mins 41s for non-culprit strategy and 8 mins 9s for culprit strategy. The non-culprit strategy therefore incurred a delay of 7 mins 32s ($p < 0.01$). The mean D2B time was 52 mins and 66 mins for the culprit and non-culprit strategies respectively ($p < 0.05$). The percentage meeting D2B time <90mins was 86% for culprit and 78% for non-culprit strategies. Percentage meeting D2B time <60 mins (which may have additional mortality benefit) was 71% and 58% for the culprit and non-culprit strategies respectively. In our cohort, mortality was significantly lower in patients with D2B <90 mins at 2.0%, versus 4.6% in those whose D2B was >90mins ($p = 0.02$).

Conclusion A 'culprit' PPCI strategy results in significantly shorter D2B times, facilitating institutional attainment of national guideline targets, which may translate into improved patient outcomes.