

the variables showing a p value <0.100 at univariate analysis, i.e. pre-procedural cardiogenic shock [OR 9.00, C.I. (2.1–37.6), p=0.003] and CK peak [OR 1.00, C.I. (1.0–1.0), p=0.051]. Pre-procedural cardiogenic shock was the only predictor [OR 7.058, C.I. (1.2–40.6), p=0.029] of in-hospital MACCE. No significant predictors of MACCE at follow-up were found at logistic regression analysis.

Conclusion In our 10 year experience of Impella-assisted high-risk PCI, 20% patients had in-hospital MACCE and mean survival was 21 months. At follow up, MACCE rate was less than 4% and both angina and heart failure symptoms were well controlled. Pre-procedural cardiogenic shock was the only predictor of in-hospital MACCE.

Conflict of Interest No conflict of interest

72

OUT-OF-HOSPITAL CARDIAC ARREST SURVIVORS UNDERGOING EMERGENCY PCI HAVE AN EXCELLENT NEUROLOGICAL RECOVERY

¹Iliandra rams ramachenderam*, ²Anthony Mechery, ³Peter Isherwood, ³Neil Abeyasinghe, ³Alexander Zaphiriou, ³Sudhakar George, ²M. Adnan Nadir, ²Peter Ludman, ²Sagar Doshi, ²Jonathan Townend, ²sohail khan. ¹University of Birmingham; ²Queen Elizabeth Hospital Birmingham; ³University Hospital Birmingham

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Introduction Out-of-hospital cardiac arrest (OHCA) is associated with a low survival to discharge rate. We aimed to

evaluate the outcome of early Percutaneous Coronary Intervention (PCI) on the mortality rates of patients with OHCA and their neurological recovery post-intervention.

Methods Outcomes of all patients presenting to our centre with OHCA who received PCI over a 3-year period were analysed (January 2015 - December 2017). Univariate analysis was performed.

Results 65 patients were identified (80% Males, Mean age 59.9 ± 14.2 years). Chest compressions were undertaken in 60.0% of patients. The most common rhythm identified was Ventricular Fibrillation (86.2%), followed by PEA (9.2%), Ventricular Tachycardia (4.6%) and Asystole (4.6%). The mean time for patients to arrive at the cardiac centre was 51.4 ± 20.7 minutes. Post-arrest ECG revealed ST-elevation (STEMI) in 53 (81.5%) patients. 42 (64.4%) received ventilation pre-angiography and 45 (69.2%) were transferred to Intensive Care Unit (ITU) post-angiography. 18 (27.7%) were in cardiogenic shock. There was no statistical significance in the mortality rates between patients with STEMI and non-STEMI (53 vs 12; p=0.43), see Table 1. 54 patients (83.1%) survived to discharge, 30-day survival 53(81.6%), 6-month survival 53 (81.6%). 31 ventilated patients (73.8%) survived to discharge, 30-days and 6-months whereas all (100%) non-ventilated patients (n=23) survived to discharge and 30-days and 22 survived (95.7%) at 6-months (73.8 vs 100%; p=0.04). 12 patients in shock (66.7%) survived to discharge, 30-days and 6-months whereas 42 non-shocked patients (89.4%) survived to discharge, 30-days and 6-months (66.7 vs 89.4%, p=0.06).

Abstract 72 Table 1

Baseline Characteristics of Out-of-Hospital Cardiac Arrests (OHCA) patients undergoing Percutaneous Coronary Intervention at Queen Elizabeth Hospital, Birmingham. n=number of patients.	
Characteristics	OHCA undergoing PCI
Average age (years)	59.9 ± 14.2
Male, n (%)	52 (80%)
Initial rhythm, n (%)	VF= 53 (81.6) PEA= 6 (9.2) VT= 3 (4.6) Asystole= 3 (4.6)
Bystander chest compression, n (%)	39 (60)
Post-arrest ECG	STEMI= 53 (81.5) NSTEMI= 12 (18.5)
Ventilation, n (%)	42 (64.4)
Cardiogenic shock (%)	18 (27.7)
pH	7.21 ± 0.18
Lactate	6.29 ± 5.26
Outcome of OHCA patient's post-emergency PCI at Queen Elizabeth Hospital, Birmingham. n=number of patients	
Characteristics	Outcome post-emergency PCI
ITU, n (%)	45 (69.2)
Cooling catheter, n (%)	33 (73.3)
Average hospital stay (days)	ITU= 21 Non-ITU= 8
Withdrawal of life sustaining treatment <72hours, n (%)	4 (36.0)
Cerebral Performance Category (CPC) score, n (%)	1= 48 (73.8) 2= 3 (4.6) 3= 2 (3.1) 4= 1 (1.5) 5= 11 (16.9)

Abstract 73 Table 1 Outcomes at 6 months

	Dialysis N=44	Creatinine >150 N=86	P Value
Cardiovascular death	6 (13.6%)	7 (8.1%)	
Cardiac arrest	1 (2.3%)	1 (1.2%)	
Heart failure	3 (6.8%)	5 (5.8%)	
MI	4 (9.1%)	1 (1.2%)	
Angina	6 (13.6%)	8 (9.3%)	
Bleeding complication	4 (9.1%)	2 (2.3%)	
Arrhythmia	2 (2.3%)	2 (2.3%)	
MACE	15 (34.1%)	11 (12.8%)	<0.01
All-cause death	11 (25%)	11 (12.8%)	<0.05

Cerebral Performance Category (CPC) score at 30-days was as follows; 48 (73.8%) scored 1, 3 (4.6%) scored 2, 2 (3.1%) scored 3, 1 (1.5%) scored 4 and 11 (16.9%) scored 5. Significantly more patients were in CPC 1 to 3 than 4–5 (53 vs 12; $p < 0.001$), see Table 2.

Conclusion In our cohort of patients presenting with OHCA who underwent PCI, we observed an excellent survival to discharge rate. Poor neurological recovery is seen in only a minority of patients who have received PCI after successful OHCA.

Conflict of Interest None

73

OUTCOMES IN PATIENTS UNDERGOING PERCUTANEOUS CORONARY INTERVENTION WITH CHRONIC KIDNEY DISEASE

¹Thomas Kirwin*, ²Anthony Mechery, ²Vincenzo Ventruno, ²Muhammad Waqas, ²Jonathan Townsend, ²sohail khan. ¹Queen Elizabeth Hospital Birmingham, Birmingham, UK; ²Queen Elizabeth Hospital Birmingham

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Introduction Patients with chronic kidney disease (CKD) have been excluded from clinical trials evaluating the outcomes of percutaneous coronary intervention (PCI). Although studies show that CKD increases complications in patients undergoing PCI, there is still uncertainty of the long term efficacy of PCI for patients with this common problem.

Purpose To describe and compare the outcomes of patients with varying degrees of CKD following PCI and to determine in what time period they are most at risk of complications.

Method 1862 patients received PCI in our centre from June 2016 to June 2018, 130 of which had renal failure. We retrospectively compared the complication rates between two groups of patients, those who were on dialysis (44) and those with CKD stage 3 and 4 and not on dialysis (86). Baseline characteristics of the patients were evaluated and patient records were reviewed to observe their outcome at 1 month and 6 months. We defined MACE as cardiovascular death, MI, stroke, major bleeding complication and cardiac arrest.

Results Comparing the baseline characteristics there was no significant difference in mean age between the dialysis group vs the CKD stage 3/4 group (67 vs 70). However, there was a higher proportion of men in the CKD stage 3/4 group vs the dialysis cohort (84% vs 59%, $p < 0.05$). There was a

significantly higher proportion of diabetics in the dialysis vs the CKD stage 3/4 group (70% vs 55%, $P < 0.05$). Comparing outcomes at 1 month between those on dialysis and those with CKD stage 3/4, dialysed patients had a numerically higher MACE (15.9% vs 11.6%, $p > 0.05$) and all-cause mortality (13.6% vs 9.3%, $p > 0.05$), however, neither were significantly different. At 6 months, the dialysis group had a significantly higher MACE than the CKD stage 3/4 group (34.1% vs 12.8%, $P < 0.01$). The dialysis group also had significantly higher all-cause mortality (25% vs 12.6% $p < 0.05$).

Conclusion Patients with chronic kidney disease undergoing PCI have a high morbidity and mortality rate. When we split the groups, patients on dialysis have a worse outcome with higher morbidity and mortality at 6 months compared to those with CKD stage 3/4 and not on dialysis. The period of highest risk for MACE extended throughout the 6 months in the dialysis cohort, whereas, those not on dialysis were at highest risk in the first month. The outcomes at 6 months can be seen in table 1.

Conflict of Interest No conflict of interest for all authors

74

DAY CASE DRUG COATED BALLOON ONLY ANGIOPLASTY FOR DE NOVO CORONARY ARTERY DISEASE

¹Ioannis Merinopoulos*, ²Upul Wickramarachchi, ²James Wardley, ²Vikram Khanna, ¹Tharusha Guanawardena, ²Clint Maart, ¹Vassilios Vassiliou, ³Simon Eccleshall. ¹University of East Anglia, Norfolk & Norwich University Hospital; ²Norfolk & Norwich University Hospital; ³Norfolk @ Norwich University Hospital

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Introduction The high pressures on hospital beds necessitate fast and efficient, yet safe turn-around of all elective patients ideally as day cases. Although same day discharge in patients receiving a coronary stent is widely supported by evidence, no prior study has reported on this strategy in Drug Coated Balloon (DCB) only de novo angioplasty. An important safety consideration, particularly with DCB only angioplasty is acute vessel closure due to a higher risk of coronary dissection, which will usually be apparent peri-procedurally. In this abstract we report our experience with day case DCB only angioplasty from a single high-volume UK centre and propose criteria for safe discharge.