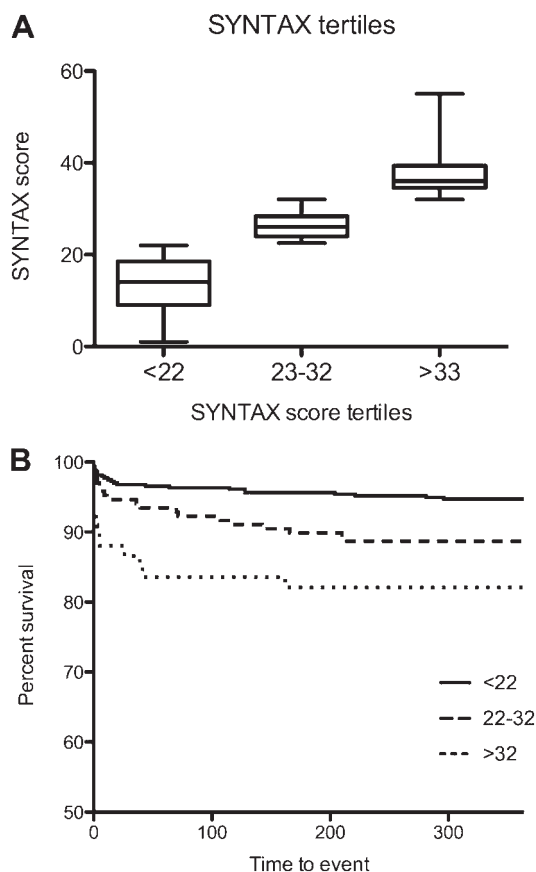


unavailable). The ability to allocate a SYNTAX tertile was reproducible between observers ($r=0.94$). Median scores in the 3 groups were: L 14, IM 26, H 36 (Abstract 43 figure 1A). Although there was no correlation between SYNTAX score and patient sex or diabetic status, there was a linear relationship with patient age ($r^2=0.03$; $p<0.0001$). 1-year absolute survival (Abstract 43 figure 1B) followed SYNTAX score groups: L 94.7%, IM 88.7%, H 82.1% ($p=0.0002$). Similar results were obtained for freedom from death or unplanned revascularisation ($p<0.0001$) and death or any revascularisation ($p<0.0001$).



Abstract 43 Figure 1

Conclusions The SYNTAX score, when applied to an unselected population of patients undergoing PPCI for STEMI, provides important prognostic information regarding 1-year survival from death and revascularisation. These findings may provide supporting evidence towards routine complete revascularisation of obstructive coronary artery disease after PPCI.

44 PRIMARY PERCUTANEOUS INTERVENTION: HAVE WE TAKEN OUR EYE OFF THE MEDICINE BALL?

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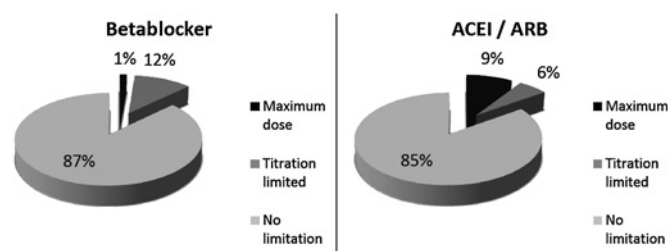
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Introduction Primary percutaneous intervention (PPCI) improves survival in patients with ST elevation myocardial infarction (STEMI). Significant resources have been directed to achieving timely reperfusion throughout the UK. However, intensive medical therapy is of equal importance, with landmark clinical trials demonstrating unequivocal morbidity and mortality benefits from β -blockers, angiotensin-converting enzyme inhibitors (ACEI), and angiotensin II receptor blockers (ARB). All trials employed rigorous titration to

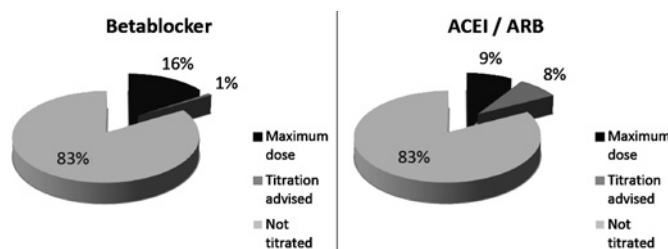
maximum clinically tolerated doses. We examined whether medical therapy is being applied appropriately in patients referred for PPCI.

Methods Consecutive patients with STEMI referred for PPCI to a large tertiary centre between 1st March and 1st August 2009 were included ($n=167$). The case records of all patients were reviewed. Myocardial infarction was diagnosed according to standard criteria. Medications and doses on admission, discharge and follow-up were recorded. Contraindications and limits to dose escalation were noted (symptoms, systolic blood pressure <90 mm Hg, heart rate <50 bpm, serum creatinine and potassium).

Results Mean age was 62.0 ± 11.9 years, 72% were male. On discharge, 100% of patients were prescribed clopidogrel, 95.8% aspirin, 98.8% statin, 88.6% β -blockers, and 91.0% ACEI/ARB. However, the inpatient dose of β -blocker or ACEI/ARB was maximum or clinically limited in only 13% and 15% of patients respectively (Abstract 44 figure 1). Outpatient follow-up at a mean of 5.0 months was equally concerning. The majority of patients (83%) were neither receiving maximum tolerated doses of β -blocker or ACEI/ARB, nor received instructions to escalate the dose (Abstract 44 figure 2).



Abstract 44 Figure 1 Inpatient titration of β -blocker and ACEI/ARB.



Abstract 44 Figure 2 Outpatient titration of β -blocker and ACEI/ARB.

Conclusion The national service framework and target driven initiatives such as advancing quality promote "tick box" medicine. Quantitative prescribing of secondary prevention is excellent. Qualitative follow-up and titration is not. Whether suboptimal doses convey the mortality benefits observed in landmark clinical trials is unknown. Frameworks to deliver titration of medical therapy must be explored. Options include nurse or pharmacy led services and expansion of cardiac rehabilitation. Reorientation is needed to focus on both quantity and quality.

45 SHOULD PRIMARY PERCUTANEOUS CORONARY INTERVENTION BE THE ROUTINE REPERFUSION STRATEGY IN OCTOGENARIANS AND NON-AGENARIANS PRESENTING WITH ST ELEVATION MYOCARDIAL INFARCTION?

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Introduction Primary percutaneous coronary intervention (PPCI) has been established as standard therapy for ST elevation myocardial infarction (STEMI). Very few trials have looked at the outcome of PPCI in elderly patients. Even in trials which claimed to have looked