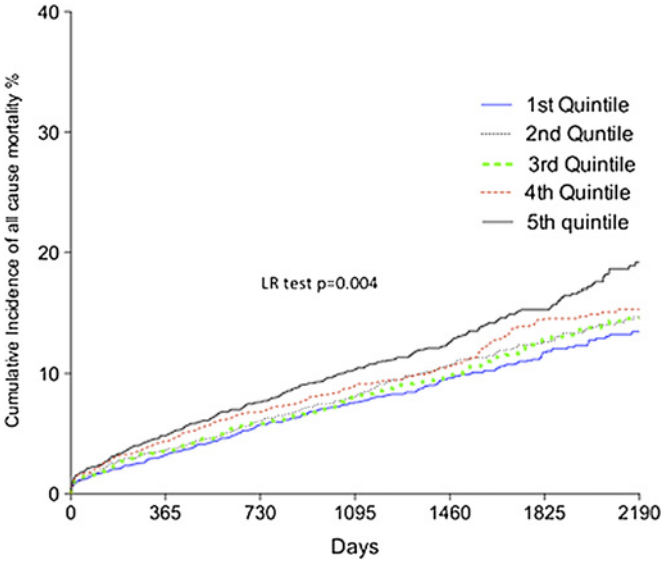
Abstract 045 Table 1 Baseline Characteristics according to socio-economic quintile (*p value <0.05)

	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

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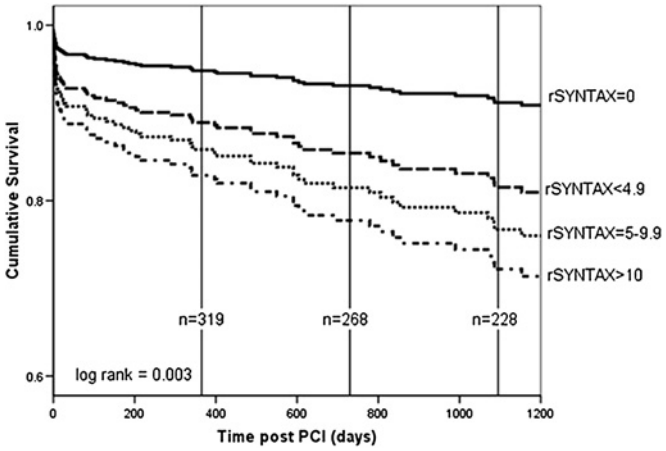
Aims To assess the impact of completeness of revascularisation upon outcome after PCI for unprotected left main stem (LMS) PCI in the "real world".

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

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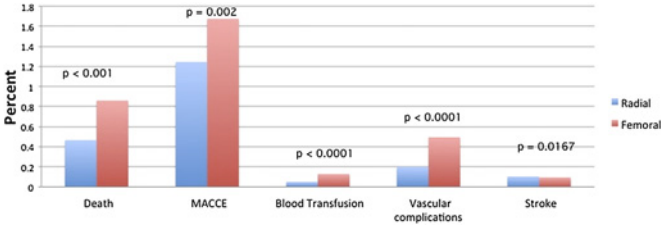
Background There has been a drive to change access site practice for PCI with the aim of reducing access site complications. This is increasingly important with the shift to more acute PCI with use of more potent antithrombotics. With the rapid uptake of transradial access in the UK we looked for changes in outcome using nationally collected data from the UK BCIS PCI dataset.

Methods Retrospective analysis of data submitted from all UK PCI centres between January 2006 and September 2011. Incomplete data and cases where multiple access sites were recorded were excluded.

Results Of 413 146 documented procedures a single access was recorded in 92.7%. The two cohorts, transradial and transfemoral were well matched for age. Transradial patients had less diabetes and fewer previous CABG but were more likely to be smokers, hypertensive, hyperlipidaemic and male. The use of transradial access increased from 17.2% in 2006 to 57% in 2011. Over this time PCI for ACS increased from 47% to 63% procedures, with the same increase in the proportion of transradial access. Primary PCI increased from 6% of all PCI to 25% in 2011. For femoral procedures mortality more than doubled (0.55% in 2006 to 1.36% in 2011) while for transradial procedures mortality only increased from 0.42% to 0.52%. When shock and IABP use are excluded the reduction in mortality for transradial PCI remains though the difference is reduced.

Conclusion The rapid change from femoral to radial access in the UK has been accompanied by a reduction in access site complications. As mortality and adverse outcomes have increased in keeping with patient and PCI complexity the rate of adverse outcomes in the patients treated radially has remained stable and lower than in the femoral group.



Abstract 047 Figure 1 In-patient outcomes following PCI January 2006 to September 2011.

Abstract 047 Table 1

	Radial	Femoral	p Value
Total number	14 6358	236 098	
Age (years)	64.04	64.85	
Diabetes	24.36%	25.25%	<0.0001
Hypertension	50.83%	47.65%	<0.0001
Hyperlipidaemia	54.98%	51.93%	<0.0001
Current smoker	24.61%	18.93	<0.0001
Never smoked	30.85%	29.34%	<0.0001
PVD	4.96%	3.94%	<0.0001
Previous MI	24.36%	25.25%	<0.0001
Previous CABG	4.83%	10%	<0.0001
Previous PCI	18.37%	20.67%	<0.0001
Previous stroke	3.93%	3.21	<0.0001

Abstract 047 Table 2

	Radial (%)	Femoral (%)	p Value
Death	0.47	0.86	<0.0001
MACCE	1.25	1.68	<0.0001
Blood Transfusion	0.05	0.13	<0.0001
Arterial Complication	0.20	0.49	<0.0001
Stroke	0.10	0.09	<0.0001

048 IS IT SAFE TO DISCHARGE PATIENTS 24 H AFTER UNCOMPLICATED SUCCESSFUL PRIMARY PERCUTANEOUS CORONARY INTERVENTION?

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Background Primary percutaneous coronary intervention (PPCI) has led to improved mortality, reduced rates of recurrent ischaemia and shorter hospital stays compared to thrombolysis. Data from our centre published previously show that in low-risk patients very early discharge at 48 h is feasible and safe. We investigated whether in a group of low risk patients stratified to 48-h discharge, 24-h discharge would be potentially feasible.

Methods We undertook an observational study at an interventional cardiology centre involving 2980 patients who underwent Primary PCI from January 2004 to July 2011. Patients with TIMI 3 flow, ST segment resolution, good or moderate left ventricular function, and no dysrhythmia post-PPCI were discharged at 2 days. Remaining higher risk patients were discharged when judged clinically fit. All patients were offered outpatient review by a multidisciplinary team. Follow-up was collected for a median of 2.8 years (IQR 1.3–4.4 years).

Results Of the 2980 patients, 1174 (39.4%) were judged suitable for 48-h discharge. Of these, 964 patients (82.1%) were discharged at 48 h, with 210 discharged after longer inpatient stays. Of these 210 patients discharged after 2 days, 150 were delayed due to timing issues (admission at unsociable hours, eg, 01:00). 60 (5.1%) patients fitting criteria had their planned 48-h discharge delayed due to a clinical complication, of which 53 occurred within the first 24 h (including six MACE events and seven arrhythmias, there were no deaths) (Abstract 048 table 1). Only seven patients (0.60%) developed complications after 24 h, of which only 1 (0.09%) suffered a MACE event (target vessel revascularisation), with the remaining complications being abnormal blood tests (renal/liver function) or drug reactions (eg, rash). There were no in-hospital deaths in the 48-h group.

Abstract 048 Table 1 Reason for prolonged admission in patients initially selected for 48-h discharge

Reason	First 24 h	After 24 h	Total
MACE*	5 (0.42%)	1 (0.09%)	6 (0.51%)
Thrombocytopaenia/bleeding	15 (1.28%)	0 (0%)	15 (1.28%)
Haematoma	2 (0.17%)	0 (0%)	2 (0.17%)
Renal/liver dysfunction	2 (0.17%)	4 (0.36%)	6 (0.51%)
Infections and lung disease	7 (0.60%)	0 (0%)	7 (0.60%)
Further chest pain/STE (non-MACE)	5 (0.43%)	0 (0%)	5 (0.43%)
Arrhythmia	6 (0.51%)	1 (0.09%)	7 (0.60%)
CCF/Pulmonary oedema	2 (0.17%)	0 (0%)	2 (0.17%)
Other	9 (0.76%)	1 (0.09%)	10 (0.85%)
Total	53 (4.50%)	7 (0.60%)	60 (5.10%)

*MACE denotes major adverse cardiac events.