

**RESULTS** Two hundred forty-nine patients had LMS intervention during the study period. All non-emergency cases were discussed by the heart team. Seventy-seven percent (n=192) were male. Mean age 70 ± 12 years. Thirty-one percent of cases were elective, 44% NSTEMI, 25% STEMI. Seventy-seven percent of procedures were performed trans-radially. Anatomical distribution: 19% ostial, 31% shaft and 50% bifurcation. Additional intra-coronary imaging was used in 55%. Ninety-two percent of patients had DES. Twenty-two percent of patients had severe LV impairment pre-procedure and 13% were in cardiogenic shock on presentation. 4.8% had acute LMS occlusion and 0.4% had chronic occlusion. Rotablation was used in 16%. Thirty-five patients (14%) required IABP support. PCI techniques included: Culotte 19%, 2-stent crush in 2%, T-stenting in 11% and single stent in 68%. Seventy-three percent had PCI on additional lesions at the same setting. Periprocedural complications included: coronary perforation in 1.2%, side branch occlusion in 3.2%, heart block requiring pacing in 0.8%, and cardiogenic shock induced by procedure in 2.4%. 98.4% of procedures were successful. No patients required emergency transfer for CABG. There were 25 (10%) in-hospital deaths. Sixty-eight percent of in-hospital deaths occurred in patients undergoing primary PCI for STEMI. Seventy-two percent of patients who died were in cardiogenic shock at presentation. Twelve-month MACE was 19.6%. Death occurred in 14%, MI in 2.4%, TVR in 2.4% and stroke in 0.8% (ischemic etiology).

**CONCLUSION** These results highlight the safety and efficacy of unprotected LMS PCI in a non-surgical centre.

**MULTIVESSEL DISEASE**

**CRT-100.53**

**Identification Of Candidates For Coronary Artery Bypass Grafting In Patients With Multivessel Disease Admitted With STEMI: A Single-center Descriptive Study**



Ramon Rodriguez-Olivares, José López-Menéndez, María Abellás-Sequeiro, Jose M. Vieitez-Flórez, Alvaro Lorente-Ros, Luisa Salido-Tahoces, Javier Miguelena, José Luis Mestre-Barceló, Marcelo Sanmartín, Jorge Rodríguez-Roda-Stuart, Rosana Hernández-Antolín, Jose L. Zamorano-Gómez  
Ramon y Cajal University Hospital, Madrid, Spain

**BACKGROUND** The management of multivessel coronary artery disease (MVD) in STEMI setting is under debate. Complete surgical revascularization with CABG is not usually considered due to the need for emergency revascularization of the culprit vessel, which is performed faster percutaneously. Many patients who are good candidates for CABG initially are not considered due to high risk of bleeding with DAPT and reduction of the anatomical complexity after the primary PCI. The use of short half-life antithrombotic therapy, i.e., GP IIb/IIIa inhibitors or cangrelor, could make possible the realization of CABG during hospitalization in selected patients after a provisional percutaneous revascularization without stent implantation of the culprit vessel. We sought to identify the percentage of patients with MVD in STEMI setting who could have been candidates for CABG.

**METHODS** We evaluated all patients admitted with STEMI in a tertiary center from April 2014 to October 2016. Those patients with TIMI flow < 3 in the culprit vessel, additional stenosis > 50% in an epicardial vessel or sidebranch > 2 mm were selected. We analyzed epidemiological variables, surgical risk scores and Syntax-I and Syntax-II scores. All patients selected were discussed in a heart-team post hoc where an interventional cardiologist (RRO) and a cardiothoracic surgeon (JLM) agreed on the best management.

**RESULTS** Three hundred seventy-nine patients were admitted due to STEMI in the aforementioned period. Seventy-two (19.0%) accomplished MVD criteria (65 +/- 13 years; 81.9% male; 29.2% diabetics; Euroscore 9.9 +/- 7.5; Euroscore-II 2.6 +/- 1.9). Syntax-I score was 19 +/- 13 points and Syntax-II score recommended CABG in 12 patients (16.7%) and heart-team discussion in 60 (83.3%). Post hoc heart-team discussion concluded that 21 (29.2%) patients could have been good candidates for complete revascularization with CABG.

**CONCLUSIONS** After a post hoc heart-team discussion, around 30% of patients admitted with STEMI and MVD could have been candidates for CABG. A provisional percutaneous revascularization without stent implantation and the use of short half-life antithrombotic therapy could make possible the realization of CABG during hospitalization in selected patients.

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**Culpritvessel-only Versus Multi-vessel Percutaneous Coronary Intervention In Patients With Cardiogenic shock complicating ST-segment-elevation Myocardial Infarction outcomes In Short Term Mortality: An Updated Meta-analysis**



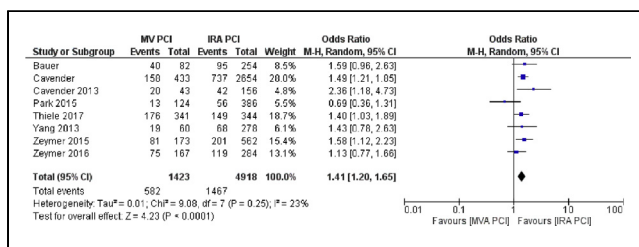
Jai D. Parekh,<sup>1</sup> Abhishek Thandra,<sup>1</sup> Gaurav Aggarwal,<sup>1</sup> Michael White,<sup>1</sup> Rohit Arora<sup>2</sup>

<sup>1</sup>Creighton University Medical Center, Omaha, NE; <sup>2</sup>University of Chicago School of Medicine, Chicago, IL

**BACKGROUND** In patients who have acute myocardial infarction with cardiogenic shock, early revascularization of the culprit artery by means of percutaneous coronary intervention (PCI) improves outcomes. However, the majority of patients with cardiogenic shock have multi-vessel disease, and whether PCI should be performed immediately for stenosis in non-culprit arteries is controversial. The optimal revascularization strategy in patients with multi-vessel disease presenting with cardiogenic shock complicating ST-segment-elevation myocardial infarction remains unknown.

**METHODS AND RESULTS** Databases were searched from 1999 to November 2017. Studies comparing immediate/single-stage multi-vessel percutaneous coronary intervention (MV-PCI) versus culprit vessel-only PCI (CO-PCI) in patients with multi-vessel disease, ST-segment-elevation myocardial infarction, and cardiogenic shock were included. Primary end point was short-term (in-hospital or 30-day) mortality. The meta-analysis included 8 studies and 6341 patients (1423 MV-PCI and 4918 CO-PCI). There was a significant difference in short-term mortality with MV-PCI versus CO-PCI (odds ratio [OR], 1.41; 95% confidence interval [CI], 1.20-1.65; P<0.05).

**CONCLUSIONS** This updated meta-analysis, which includes the multicenter randomized control trial CULPRIT SHOCK, suggests that in patients with cardiogenic shock complicating ST-segment-elevation myocardial infarction, there is a significant benefit in short-term mortality with CO-PCI compared with MV-PCI. Given the limitations of observational data, more randomized trials are needed to validate these findings.



**OTHER**

**CRT-100.67**

**The Correlation Between The Extent Of Mitral Annulus Calcification And The Severity Of Coronary Artery Disease**



Ali Elsharkawi,<sup>1</sup> Mohamed Mahmoud,<sup>2</sup> Mohamed Salah Abd Elsalam,<sup>2</sup> Tarek Bakr<sup>2</sup>

<sup>1</sup>National Heart Institute, Cairo, Egypt; <sup>2</sup>AlAzhar University Cardiology Departments, Assuit, Egypt