higher cancer mortality. Even in the emergent PCI patients, comparable results were obtained. Multivariate Cox proportional hazard analysis showed that prior cancer was an independent predictor of mortality (HR 2.10 [1.38 - 3.18], p=0.0005).

CONCLUSION In conclusion, patients with prior cancer had higher mortality than those without prior cancer. It depends on cancer mortality, even in patients undergoing emergent PCI.
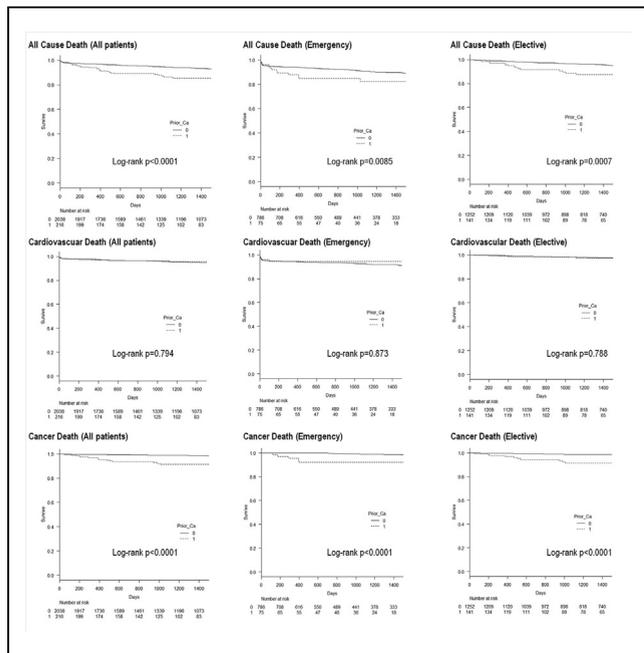
CRT-100.76

Correlation Between the Presence Of Aortic Valve Sclerosis and Severity of Coronary Artery Disease

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BACKGROUND Despite improvements in risk scoring assessment of CAD, patients at low risk still experience CHD events.

AIM OF STUDY To evaluate whether the severity of aortic valve sclerosis without mitral annular calcification could be a predictor for the extent of coronary artery disease in patients ≤ 65 years.

PATIENTS AND METHODS Fifty patients less than 65 years old without aortic stenosis or bicuspid aortic valve or rheumatic heart or HCM or renal failure were referred for coronary angiography between January 2015 and April 2017. The study subjects were divided into Group I - 20 patients with normal aortic andmitral valves, and Group II - 30 patients with aortic valve sclerosis without mitral annulus calcification.

METHODS Patients were subjected to TTE where AVS was defined as a focal area of increased echogenicity and thickening of the aortic valve leaflets without restriction of leaflet motion and a transaortic flow velocity (<2.5 m.s). The thickness was determined from the end diastolic frozen echo images obtained in short or long axis. CAD was graded using coronary catheterizations according to Friesinger score, which ranges from 0 to 15, each of the three main coronary arteries is scored separately from 0 to 5. Score 0: No arteriographic abnormality, Score 1: Trivial irregularities (lesion from 1-29%), Score 2: Localized 30-68% luminal narrowing, Score 3: Multiple 30-68% luminal narrowing of same vessel, Score 4: 69-100% luminal narrowing without 100% occlusion of proximal segments, and Score 5: Total obstruction of a proximal segment of a vessel.

RESULTS Friesinger score was significantly higher in the sclerotic group (7.30 ± 2.87) compared to the normal group (2.50 ± 2.21) (P < 0.001) linking AVS to CAD.

CONCLUSION AVS is strongly interrelated to the extent and severity of coronary atherosclerosis.
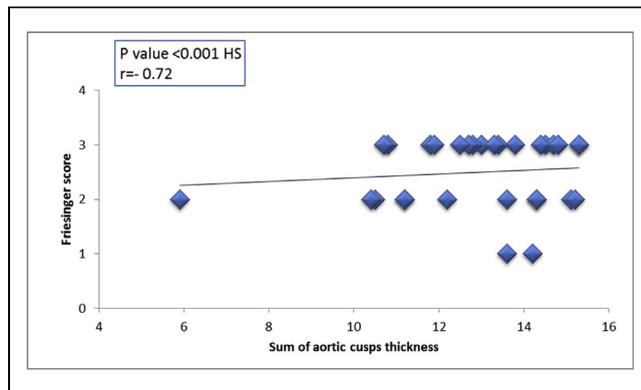
CRT-100.77

Trends In National Hospitalization Rates With Abnormal Stress Tests - Impact of the COURAGE Trial

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OBJECTIVE To assess trends in hospitalization rates among patients with an abnormal stress test in the eras before and after publication of the Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation (COURAGE) trial.

BACKGROUND Based on contemporary literature, trends in patients hospitalized for an abnormal stress test is unknown. The COURAGE trial demonstratedthat major cardiovascular events were not reduced with percutaneous coronary interventions (PCI) when added to optimal medical therapy in a population of patients with stable ischemic heart disease, including those with an "abnormal" stress test. Moreover, the impact of the COURAGE trial on the decision to treat patients in-hospital with stable ischemic heart disease and an "abnormal" stress test has not been evaluated.

METHODS We queried the Nationwide (National) Inpatient Sample (NIS) to identify patients being admitted for an "abnormal" stress test with a principal discharge ICD 9 CM diagnostic code of 794.39 from 2003 to 2014. The COURAGE trial was published in 2007. We evaluated the impact of that publication by assessing trends of in-hospital management of patients with a principal discharge diagnosis of an abnormal stress test before and after 2008 using a non-parametric test for trends.

RESULTS From 2003 to 2007, there appears to have been an increase in the in-hospital management of patients with an abnormal stress test (p-trend <0.001). Since 2008, post publication of the COURAGE trial, there appears to have been significant reduction in this trend (p-trend <0.039).

CONCLUSIONS There appears to be a recent reduction in the trend of in-hospital management of patients with an abnormal stress test, which appears to be co-incident with the publication of the COURAGE trial.
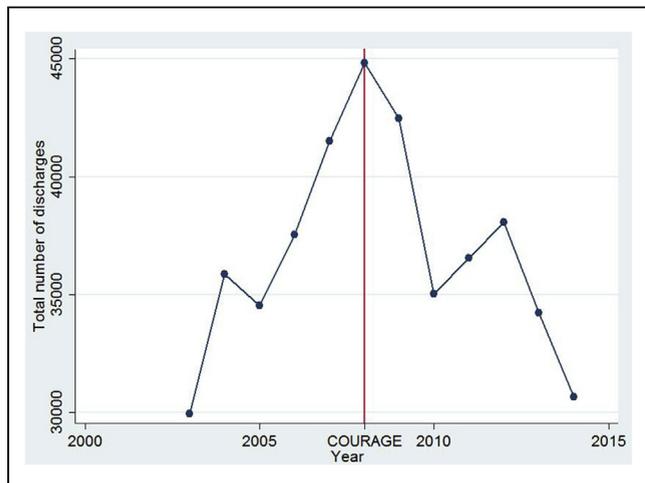
CRT-100.78

ACE Inhibitors and ARBs In Post-percutaneous Coronary Intervention Contrast-induced Nephropathy (CIN): To Hold or Not to Hold?

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BACKGROUND Contrast-induced nephropathy (CIN) is a frequent adverse outcome from percutaneous coronary intervention (PCI). It is common practice to hold angiotensin-converting enzyme inhibitors (ACEI) and angiotensin receptor blockers (ARB) in patients who develop CIN, with the intention to resume as outpatients. This study investigated whether discontinuation of ACEI/ARB in post-PCI CIN was associated with differences in major adverse cardiac or cerebral events (MACCE) and initiation of hemodialysis (HD).

METHODS We performed a retrospective study of 414 patients who underwent PCI from 2008 to 2013 and developed CIN, defined as an increase in serum creatinine level of 0.5 mg/dl or 25% from baseline at 48-72 hours after contrast exposure. One hundred fifty-one patients were identified after excluding those who did not meet the criteria for CIN or were not taking ACEI/ARB prior to hospitalization. Chi-square, Fisher's exact, and Wilcoxon rank-sum tests were used to analyze differences in MACCE or HD between post-PCI CIN patients who continued versus discontinued ACEI/ARB. Cox regression analysis was used to assess ACEI/ARB continuation status as a predictor of MACCE or HD.

RESULTS Among the 151 patients with CIN, 77 (51%) had their ACEI/ARB continued at hospital discharge, 47 (31%) had their ACEI/ARB discontinued, and 27 (18%) died during hospitalization. There were no significant differences in MACCE or HD between patients in the ACEI/ARB continuation versus discontinuation groups at 1 year of follow-up; however, there was a trend toward more PCI in patients who discontinued ACEI/ARB (17% versus 6.5%, p = 0.076). Cox regression analysis demonstrated that continuation of ACEI/ARB at hospital discharge was not a statistically significant predictor of MACCE or HD at 1 year of follow-up.

CONCLUSION In patients with CIN after PCI, there is no benefit from holding ACEI/ARB at hospital discharge. Further prospective studies should be performed to confirm these findings.

CRT-100.79

Impact on Clinical Decision-making Process of Two Formulas to Calculate Diameter Stenosis of Coronary Lesions: From Benchmark to Real Cases
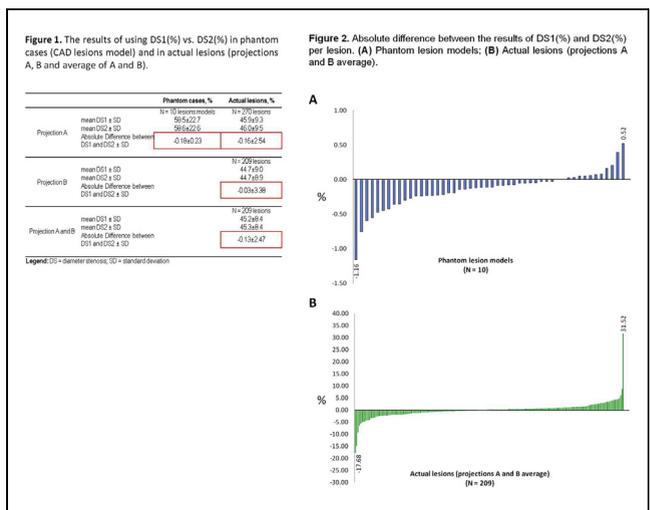
Alexandre Hideo-Kajita, Viana Azizi, Yael F. Meirovich, Gebremedhin D. Melaku, Kayode O. Kuku, Aaphtaab Dheendsa, Solomon S. Beyene, Echo J. Bratwaite, Yuichi Ozaki, Sameer Desale, Ron Waksman, Hector M. Garcia-Garcia
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BACKGROUND The 2016 American guidelines for percutaneous revascularization recommend treatment of coronary artery lesions based on diameter stenosis (DS). However, due to the high inter-operator variability in the visual assessment of DS, quantitative coronary analysis (QCA) is the gold standard to assess it. Moreover, there are two DS formulas currently in use, which either use the average of the reference segments (DS1%) or the interpolated reference vessel diameter (DS2%). The aim of this study is to evaluate the difference between DS1% and DS2% assessed by QCA in two datasets, phantom lesion model (i.e., controlled ideal scenario) and actual coronary lesions.

METHODS/RESULTS Ten phantom lesion models and 209 intermediate coronary lesions (i.e., DS of 40-80%) from the FIRST trial cohort were assessed by QCA following Corelab standards. The results are presented in Figure 1. Of note, the range of the absolute difference between DS1 vs. DS2 results went from -1.16% to 0.52% in the phantom lesion models, and in the actual lesions dataset the range went from -17.68% to 31.52% (projections A and B) (Figure 2).

CONCLUSION The variability of the absolute differences, expressed as standard deviation (SD), of different DS formulas revealed a very narrow range in the phantom lesion model, while the opposite was observed with regard to the SD in the actual cases. Similarly, the range of the differences between DS1 and DS2 was larger in the actual cases compared to the narrow range of the phantom. Clinician and researchers need to be aware of these important differences in results (using different formulas) when looking at the diameter stenosis results.

Figure 1. The results of using DS1(%) vs. DS2(%) in phantom cases (CAD lesions model) and in actual lesions (projections A, B and average of A and B).

Figure 2. Absolute difference between the results of DS1(%) and DS2(%) per lesion. (A) Phantom lesion models; (B) Actual lesions (projections A and B average).

CRT-100.80

Race, Contrast-induced Nephropathy and Long-term Outcomes After Coronary and Peripheral Angiography and Intervention

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BACKGROUND Contrast-induced nephropathy (CIN) is a complication of diagnostic angiography and percutaneous coronary and endovascular intervention. It is associated with diabetes and chronic kidney disease, both diseases which are associated with poorer outcomes in non-Caucasians. We investigated the effect of race on the development of CIN.

METHODS We studied 4070 predominantly (98%) male patients undergoing peripheral and coronary angiography and percutaneous coronary and endovascular intervention at a Department of Veterans Affairs medical center. We analyzed the incidence of CIN at 72 hours, of renal dysfunction at 3 months as well as the incidence of hemodialysis and of death. CIN was defined as either a rise in creatinine of 25% or an absolute rise in creatinine of 0.5 mg/dl.