Variables	Cost of Care					Length of Stay				
	N	Sum of weights	Mean	Std Dev	P-value	N	Sum of weights	Mean	Std Dev	P-value
Chronic Kidney Disease					<.0001					<.0001
No CKD	93234	466170.07	23264.47	49712.96		94868	474340.08	3.99	11.09	
CKD with HD	1583	7915.00	32666.53	104940.53		1617	8085.00	7.57	26.06	
CKD without HD	9928	49640.01	25696.78	63024.39		10239	51195.02	5.86	13.97	
Age					<.0001					<.0001
18-34	1255	6275.00	21719.40	59155.54		1271	6355.00	3.49	11.17	
35-49	14536	72680.02	22640.88	48564.39		14789	73945.03	3.54	10.34	
50-64	41628	208140.04	24448.06	52558.18		42370	211850.04	4.04	12.12	
65-79	31313	156565.04	25354.21	56883.79		31949	159745.04	4.64	12.64	
≥80	16013	80064.98	19225.75	43971.62		16345	81724.99	4.58	10.68	
Gender					<.0001					0.0051
Female	33606	168030.01	21877.15	46008.89		34281	171405.01	4.39	10.92	
Male	71139	355695.07	24468.50	55139.47		72443	362215.09	4.15	12.28	
Cardiogenicshock					<.0001					<.0001
No	92682	463410.06	21075.67	37069.27		94451	472255.08	3.74	9.14	
Yes	12063	60315.02	43316.95	105569.97		12273	61365.02	7.99	22.38	
Charlson/Deyo comorbidity index					<.0001					<.0001
1	41741	208705.05	20197.42	28678.44		42445	212225.05	2.95	6.11	
2	30281	151405.00	23309.28	49566.84		30789	153945.01	4.00	10.98	
>2	32723	163615.03	28328.05	72790.91		33490	167450.04	6.05	16.23	
Primary payer					<.0001					<.0001
Medicare/Medicaid	55719	278595.04	23595.01	54776.18		56822	284110.05	4.64	13.20	
Private includingHMO	35084	175420.03	24000.12	50615.16		35858	179290.03	3.74	9.83	
Self pay/nocharge/other	13942	69710.01	22891.79	47207.35		14044	70220.01	3.81	10.53	
Admission day					0.1994					0.0378
Weekend	29284	146420.01	23456.93	50402.31		29811	149055.02	4.13	11.46	
Weekday	75461	377305.07	23707.02	53227.44		76913	384565.08	4.26	12.02	
Hospital region					<.0001					<.0001
Northeast	18217	91085.00	24545.55	59624.43		18264	91320.00	4.63	12.93	
Midwest	24368	121839.88	23372.79	50405.36		25222	126109.90	3.98	10.79	
South	42560	212800.15	21552.02	44302.06		42579	212895.15	4.31	12.00	
West	19600	98000.05	27648.95	62026.61		20659	103295.05	4.00	11.80	
Hospital teaching status					<.0001					<.0001
Rural	9091	45454.97	18380.84	40707.30		9165	45824.97	3.38	8.32	
Urban non teaching	38047	190235.00	22456.80	41503.15		38629	193145.01	3.92	9.96	
Urban teaching	57607	288035.11	25246.13	59701.47		58930	45824.97	3.38	8.32	
Hospital bedsize					<.0001					<.0001
Small	11844	59220.08	20056.12	38340.55		12172	60860.08	3.61	9.27	
Medium	27312	136559.98	22344.46	46446.27		28153	140765.00	3.95	10.20	
Large	65589	327945.03	24822.02	56640.13		66399	331995.02	4.45	12.87	

CRT-100.17

Prognostic Impact of Ischemic Preconditioning in Patients Presenting for Acute ST-elevation Myocardial Infarction

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BACKGROUND Ischemic preconditioning (IP) is associated with lesser myocardial infarct size in animal studies. In humans, when occurring before ST-elevation myocardial infarction (STEMI), the prognostic significance of IP episodes is still controversial. In this study, we sought to determine prognostic features associated with IP in patients admitted for STEMI.

METHODS The present study was carried out on our single-center retrospective STEMI registry. The registry enrolled 1498 patients presenting with STEMI between January 1998 and September 2014. Exploitable data from only 1404 patients were analyzed. Patients were managed by prehospital thrombolysis, primary percutaneous coronary intervention or conservatively (i.e., with no reperfusion therapy). Patients experiencing recurrent ischemic symptoms before the index STEMI were part of the IP group. Those with no symptoms were part of the Inaugural group. Univariate and multivariate predictors of in-hospital mortality, including IP, were studied.

RESULTS Out of the study population, 442 (31.5%) patients were part of the IP group. Compared with the patients in the Inaugural group, patients in the IP group had more frequent arterial hypertension (36.7% vs. 27%, $p<0.001$), diabetes mellitus (41% vs. 32.7%, $p=0.003$) and a history of coronary artery disease (21% vs. 6.2%, $p<0.001$). Prevalence of heart failure on presentation was not significantly higher in the IP group. In-hospital mortality rate was significantly lower in the IP group compared to the Inaugural group (5.9% vs. 10.6%, $p=0.004$). In univariate analysis, the absence of IP, advanced age, female gender, arterial hypertension, diabetes mellitus, heart failure on presentation, and cardiogenic shock were significantly associated with in-hospital death. In multivariate analysis, in addition to other predictors, the absence of IP was independently associated with in-hospital death (HR: 2.38, 95% CI: 1.47-3.84, $p<0.001$).

CONCLUSION According to our study, although associated with cardiovascular risk factors, IP in patients presenting with STEMI is independently associated to better in-hospital outcomes.

CRT-100.18

Impact of Chronic Kidney Disease on Clinical Outcomes Among Patients Admitted With Acute ST-Elevation Myocardial Infarction: A Nationwide Inpatient Sample 2012-2014

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INTRODUCTION Chronic kidney disease (CKD) in patients with ST-elevation myocardial infarction (STEMI) is a poor prognostic factor. The objective of this study is to assess clinical outcomes among patients with CKD admitted for acute STEMI.

METHODS A nationwide inpatient sample database from 2012-2014 was used to identify all patients admitted to hospital with STEMI using International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes ($n=534{,}845$). Patients with dialysis-dependent CKD ($n=8100$) and CKD without dialysis ($n=51{,}285$) were compared to non-CKD patients (475,460). Clinical outcomes were measured. Hierarchical logistic regression was performed, and $p<0.05$ was considered as the level of significance.

RESULTS The rate of any cardiac complication was 2.45% in non-CKD patients. Compared to non-CKD patients, any cardiac complication was lower in CKD patients without dialysis (1.99%, $p<0.0001$) and similar in dialysis-dependent CKD patients (2.35%, $p=0.553$). Hemorrhage or hematoma was revealed in 10.66% of non-CKD patients. Compared to non-CKD patients, hemorrhage or hematoma was significantly higher in CKD patients without dialysis (17.84%, $p<0.0001$) and dialysis-dependent CKD (20.37%, $p<0.0001$). Compared to non-CKD patients (7.17%), acute renal failure was higher in CKD patients without dialysis (40.62%, $p<0.0001$). Detailed data on results in form of percentage are highlighted in Figure 1.

CONCLUSION Compared to non-CKD patients, CKD patients who present to hospital with STEMI have higher complications including markedly higher hemorrhage or hematoma and acute renal failure.

Outcomes	CKD without HD	no CKD	Overall	P-value	CKD with HD	no CKD	Overall	P-value
Any cardiac complications				<0.0001				0.5539
No	98.01	97.55	97.60		97.65	97.55		
Yes	1.99	2.45	2.40		2.35	2.45		
Cardiogenicshock				<0.0001				<0.0001
No	82.16	89.34	88.64		79.63	89.34		
Yes	17.84	10.66	11.36		20.37	10.66		
Hemorhage or Hematoma				<0.0001				0.013
No	97.51	97.87	97.84		97.47	97.87		
Yes	2.49	2.13	2.16		2.53	2.13		
Anemia or hemorrhage requiring blood transfusion				<0.0001				<0.0001
No	89.88	96.61	95.96		82.35	96.61		
Yes	10.12	3.39	4.04		17.65	3.39		
Vascular complications				0.1677				0.1135
No	99.98	99.97	99.97		99.94	99.97		
Yes	0.02	0.03	0.03		0.06	0.03		
Post-op respiratory failure				<0.0001				<0.0001
No	98.37	98.93	98.88		97.35	98.93		
Yes	1.63	1.07	1.12		2.65	1.07		
Post-op infarct or hemorrhage				<0.0001				<0.0001
No	99.77	99.85	99.84		99.63	99.85		
Yes	0.23	0.15	0.16		0.37	0.15		
Acute renal failure				<0.0001				<0.0001
No	59.38	92.83	89.57		85.25	92.83		
Yes	40.62	7.17	10.43		14.75	7.17		
New Temporary Pacemaker				<0.0001				<0.0001
No	96.65	97.57	97.48		96.11	97.57		
Yes	3.35	2.43	2.52		3.89	2.43		
New Permanent Pacemaker				<0.0001				<0.0001
No	98.63	99.54	99.45		98.83	99.54		
Yes	1.37	0.46	0.55		1.17	0.46		
Pericardial complications				0.0074				<0.0001
No	99.62	99.69	99.68		99.26	99.69		
Yes	0.38	0.31	0.32		0.74	0.31		

CRT-100.19

Utility Of Post-Procedural Anticoagulation after Primary PCI for STEMI: Cardiac Magnetic Resonance and 2D-Echocardiographic Findings

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BACKGROUND Controversy exists as to whether and how long anticoagulation is necessary after primary percutaneous coronary