

functional class, actually 2 patients died, the first one died at the next 8 months and the second one at the 18 months. From the control Group 6 patients died in the first year, in the next six months 3 more patients died and all 6 patients stayed in III and the rest in IV functional class. The left fraction ejection improve in a average 5%, but in all the patients the therapeutic medication were reduced. From the control group we found that 80% of the patients were hospitalized around 3 or 4 times per year and in the experimental group only 10%.

Conclusion: This technique is effective for treat patients with refractory heart failure, besides being easy to apply, during the procedure there were no deaths, and functional class improved significantly for patients in a period of 6 months until these period. The containment of the discinetique zone with a mechanical barrier effect, promoted the consequent increase in the contractility of the rest of the walls. This clinical trial is innovative for the treatment of refractory heart failure using a percutaneous technique.

CRT-159

Multi-Center Prospective Study to Evaluate Outcomes of Moderate to Severely Calcified Coronary Lesions (MACE): Study Design and Acute Outcomes

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Background: Recently presented retrospective analysis comparing none, moderate, and severely calcified coronary lesions showed that percutaneous coronary intervention (PCI) patients that have moderate/severely calcified coronary lesions have poorer outcomes than patients with none/mild calcified coronary lesions.

Methods: MACE study conducted by Cardiovascular Systems Inc. (CSI) is the first study that will prospectively monitor PCI outcomes in patients with varied degrees of calcification in coronary lesions. This study will enroll up to 500 subjects in up to 50 U.S. study sites. The objectives of the MACE study are to: 1) assess current standard of care treatment outcomes in none/mild (n=100), moderate (n=200), and severe (n=200) calcified coronary lesions. 2) Obtain financial data and procedure data to support reimbursement initiatives and health care economics analysis. Subjects scheduled for endovascular treatment involving stent deployment in *de novo* coronary lesions are qualified to be included in the study. Endovascular treatment is defined as treatment with commercially available devices that may include but is not limited to balloon, cutting balloon, Rotablator, etc. followed by the stent placement. The subjects will not be included in the study if 1) diagnosed with chronic renal failure unless under hemodialysis or has a serum creatinine level >2.5 mg/dl; 2) have evidence of current LVEF $\leq 25\%$; 3) have history of major cardiac intervention within 30 days, not including a PCI procedure for a staging purpose; 4) have uncontrolled insulin dependent diabetes.

Results: The primary endpoint is to assess the current standard of care treatment when used to facilitate stent deployment in *de novo*, coronary lesions. This will be measured by a composite of major adverse cardiac events (MACE) at 30 days and 1-year post procedure. MACE is composed of cardiac death; myocardial infarction (MI) – defined as a CK-MB level > 3 times the upper limit of lab normal (ULN) value with or without new pathologic Q wave; and target vessel revascularization (TVR) – defined as revascularization at the target vessel (inclusive of the target lesion) after the completion of the index procedure. Secondary endpoints include procedural success and health economics.

Conclusion: An interim analysis of acute outcomes will be presented on up to 50 subjects that have completed the discharge visit.

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Same Day Discharge After Elective Percutaneous Coronary Interventions: A Single Center Experience in Contrast to the National Average

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Background: Patients undergoing elective Percutaneous Coronary Interventions (PCI) are generally observed overnight in the hospitals, mainly because of the fear of the PCI related complications. Prevalence of same day discharge after elective PCI is still very low in the United States (1.5% as quoted in recent studies), with variation across the facilities and the operators.

Methods: Information from a pre-existing quality assurance database was identified and used in this retrospective review. All patients undergoing elective PCI between a 2 year period at a single center with five different operators were selected. Information regarding clinical characteristics, co-morbidities, anatomic & procedural details, immediate complications, re-hospitalization and mortality within 30 days was collected.

Results: 372 patients had elective PCI, 95 (25.5%) were discharged the same day. Among the radial group, 78 (36.6%) out of 213 patients and femoral 17(10.8%) of the 157 patients were discharged the same day. One of the operators discharged 82% (37/45) of his elective patients the same day. 30% of the patients had age >70 years, 15% had GFR <60 and 2% had GFR <30 , 24% had LVEF <60 and 2.1% had LVEF <30 . None of them had immediate procedural complications. Overall, there were no deaths at 30 days and four patients were hospitalized. Post procedure day 3 sub acute stent thrombosis due to clopidogrel non compliance, day 9 with radial artery pseudoaneurysm, and day 28 with chest pains, none of which could have been prevented by overnight hospital stay.

Conclusions: Same day discharge after elective PCI at our institution was significantly higher than the national average and had operator variability. There was no mortality, post procedural complications or repeat hospitalizations within 30 days that could have been prevented with overnight observation. Simple success or failure of the procedure without intraprocedural complications seems to be the important distinguishing feature of a PCI that can define who can safely be discharged.

CRT-161

Utility of Clinical Risk Scoring Systems in Predicting Long Term Outcome After Percutaneous Coronary Intervention in a Veterans Affairs Medical Center

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Background: Veterans Affairs Medical Center (VAMC) patients undergoing after Percutaneous Coronary Intervention (PCI) have multiple co-morbidities and cardiovascular risk factors. The NCDR Risk score is a clinical risk score to predict the risk of in-patient mortality after PCI. The ACEF is a simpler clinical risk scoring system that incorporates 3 variables- Age, Creatinine and Ejection Fraction to predict outcomes after PCI and is a predictor of death 1 year post procedure.

Objective: We wanted to evaluate if these clinical scores are applicable to a VAMC population and assess its utility in predicting long term survival outcomes and compare the scoring systems.

Methods: NCDR risk scores and ACEF scores were calculated for 361 consecutive patients undergoing PCI and were correlated with their 3 year mortality. Kaplan-Meier (KM) Survival Analyses of low (≤ 10), intermediate (11 to 30) and high (>30) NCDR score were performed with 3 year mortality data. ACEF and NCDR scores were co-related with their 3 year outcomes.

Results: Average ACEF score of patients who died during the 3 year follow up were significantly lower than those who survived. None of the 65 patients with NCDR score ≤ 10 died while 22 of the 52 (42%) with a score >30 died within 3 years. KM survival analyses of patients stratified by NCDR score confirmed significant increase in the 3 year mortality of the patients with higher scores. This is the first report comparing NCDR and ACEF scores in a VA population with long term survival outcomes.