

bypass, 30-day MI, 30-day TVR, or stent thrombosis. 1 (0.9%) patient had a stroke within 30 days of PCI. Restenosis occurred in 3.6% of patients (n=4). 30 day mortality occurred in 1.8% of patients (n=2) due to non-cardiac causes from post-operative complications from non-cardiac surgery.

**CONCLUSION** In this first report of the commercial experience with coronary OAS, procedure success, adverse events, and clinical outcomes were favorable. This data demonstrates the safety and effectiveness of OAS in treating severely calcified coronary artery disease.

Baseline and Procedural Characteristics

AgeGenderBody Weight	7462.5% Male79.4Kg
DMHTNDyslipidemia	50.9%100%92%
Current SmokerRenal Insufficiency (Cr>1.5) Dialysis Dependent	7.1%25.9%67.1%
Prior MI/Prior PCI/Prior CABG	20.5%37.5%18.8%
CVAPVDEF	13.4%22.3%48%
Presenting with MIPresenting with stable anginaPresenting with unstable angina	14.3%17.9%64.3%
Avg # of vessels treatedAvg # of stentsDirect stenting	1.41.925.9%
Intravascular imaging used	9.8%
Radial access siteTemporary pacemaker placedMechanical support used	17.9%8.9%16.1%
Contrast volume usedRadiation exposureMaximum inflation pressure	137 mL24.6 mins.19.7 ATM

**CRT-200.72**  
**Cardiovascular Outcomes and Concomitant Proton Pump Inhibitors and Clopidogrel Users: Evidence From Meta-analysis**

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**BACKGROUND** Evidence on cardiovascular outcomes with concomitant pharmacotherapy with proton pump inhibitors (PPI) and clopidogrel is mixed and varies across studies. We performed a meta-analysis of studies examining this relationship in both matched and unmatched cohorts.

**METHODS** PubMed, Google Scholar and EBSCO databases were searched electronically to identify studies using concomitant PPI's and clopidogrel. Data on endpoints of mortality, myocardial infarction (MI), stroke (CVA), stent thrombosis and clinically driven revascularization was extracted. Pooled risk ratio (RR) with 95% confidence intervals (CI) was estimated using random effects model.

**RESULTS** A total of 24 studies (7 matched) were included. In the matched cohort, 7,962 and 12,225 patients were included in the PPI and non-PPI groups respectively. In the matched cohort only group there was no difference in the outcomes of mortality, MI, revascularization, stent thrombosis and CVA (Figure 1). However, in the unmatched cohort group, mortality, MI, and revascularization were significantly higher in the PPI group compared to the non-PPI group. The risk of stent thrombosis and CVA risk was not different in the two groups.

**CONCLUSION** Adverse cardiovascular outcomes were not significantly different in the PPI and clopidogrel group in the matched cohort but not in the unmatched cohort. We speculate that PPI as a class do not influence the above outcomes but may be dependent on the type of PPI, dose of PPI and dose of clopidogrel used.

Cardiovascular Outcomes with and without PPI's in Clopidogrel Users

Outcome	Matched Cohort RR (95% CI)	Unmatched Cohort RR (95% CI)
Mortality	1.19 (0.79 - 1.80)	1.40 (1.21 - 1.62)
Myocardial Infarction	1.11 (0.95 - 1.29)	1.41 (1.20 - 1.66)
Clinically driven revascularization	1.04 (0.80 - 1.34)	1.66 (1.15 - 2.39)
Stroke	1.46 (0.67 - 3.20)	1.35 (0.99 - 1.86)
Stent thrombosis	1.33 (0.84 - 2.11)	1.12 (0.61 - 2.06)

**CRT-200.73**  
**Risk Assessment and Clinical Outcomes for Surgically Rejected Octogenarians Undergoing Left Main Percutaneous Coronary Intervention**

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**BACKGROUND** Elderly patients are well known to have higher mortality rates associated with coronary surgical revascularization. The Society of Thoracic Surgeons (STS) score and the European System for Cardiac Operative Risk Evaluation (EuroSCORE) II are well known risk stratification models in which age plays an incremental factor. In the present study, we report our experience of surgically rejected octogenarians with unprotected left main coronary artery (ULMCA) stenosis undergoing percutaneous coronary intervention (PCI).

**METHODS** From April 2008 to June 2014, 71 patients with ULMCA stenosis were considered high risk for surgical revascularization and underwent PCI. Patients were divided based upon age less than 80 years (n=53) and greater than 80 years (n=18). STS, EuroSCORE II, Syntax score, use of device support and 30 day and 1 year mortality were assessed.

**RESULTS** Baseline characteristics were similar, except octogenarians had lower rates of diabetes (22% vs. 55%) and higher rates of advanced chronic kidney disease (61% vs 30%). Compared to younger patients, octogenarians had a significantly higher STS Score (14.1 ± 3.0 vs 6.5 ±9.3, p=0.009) and EuroSCORE II (17.0 ± 18.7 vs 8.2 ± 9.2, p=0.01). There was no difference in Syntax score between the 2 groups, 24.6 ± 12.1 vs 24.1 ± 12.1, p=NS. The type of device support (Intra Aortic Balloon Pump, Impella or Tandem Heart) did not differ between the groups. Need for temporary dialysis during hospitalizations did not differ (20% vs 20%, p=NS). Average length of stay was comparable (8.4 ± 8.6 vs 12.0 ±10.7, p=NS). 30 day mortality (17% vs 4%, p=NS) and 1 year mortality (28% vs 21%, p=NS) were similar between the groups.

**CONCLUSION** When compared to younger patients, octogenarians with ULMCA stenosis undergoing PCI have similar short and long-term outcomes despite having a higher baseline STS Score and EuroSCORE II.

**CRT-200.74**  
**Abstract Withdrawn**

**CRT-200.75**  
**Troponin Elevation Post PCI: Prognostic or Without Purpose?**

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**BACKGROUND** The prognostic value of post-PCI troponin elevation in the modern era is uncertain. There is conflicting data as to the predictive value of the degree of troponin elevation post-PCI.

**METHODS** We queried Dartmouth Dynamic Registry database of consecutive PCI's to identify elective PCI's with documented normal troponins at baseline between 2006 and 2015. A total of 1709 cases were identified. Baseline demographic information and procedural characteristics were collected. Post procedure troponins and in-hospital adverse outcomes including heart failure, repeat intervention, arrhythmia, bleeding, and death were collected. Outcomes between patients with mild (3 times upper limit, NCDR definition) and moderate (5 times upper limit, Joint Task Force definition) troponin elevations were compared to those patients without troponin elevation to assess for predictive value. The Fishers Exact Test was used to determine statistical significance.

**CONCLUSION** In patients undergoing elective PCI, even mild post-procedure troponin elevation is predictive of adverse in-hospital outcomes.