(p=0.13 and p=0.05, respectively) and female gender was not significantly associated with mortality (HR 1.0 p=0.9 for female gender, HR 2.00 p<0.01 for age)
Conclusions: Data from nation-wide registry of acute MI patients does not support existence of a significant gender difference in time to intervention. Apparent higher mortality of women in non-balanced sample may be explained by different age and clinical risk profile of female cases.

P5593 | BEDSIDE
VA-ECMO in primary PCI for ST-elevation myocardial infarction

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Introduction: Primary Percutaneous Coronary Intervention (pPCI) is the cornerstone in the treatment of ST-elevation myocardial infarction (STEMI). STEMI can cause great haemodynamic instability through a mechanism of cardiac failure and low output state. Veno-Arterial Extra Corporal Membrane Oxygenation (VA-ECMO) can provide haemodynamic support in patients with STEMI with cardiac failure but data on outcome and complications is scarce.
Purpose: To gain insight in the safety and efficacy of VA-ECMO in pPCI for STEMI regarding survival and complications.
Methods: An in-hospital registry was kept at the our Hospital, involving all patients who received VA-ECMO treatment for haemodynamic support after pPCI for STEMI. All patients were analysed for age, sex, medical history, coronary vessels involved, left ventricular function prior to admission, survival, complications, length of ECMO treatment and length of stay.
Results: Between 2011 and 2016 12 patients underwent pPCI for STEMI and received VA-ECMO for haemodynamic support. The majority of patients was male (10/12) with a median age of 63 (47–75) years and 4/12 patient had a previous history of coronary artery disease in the form of a previous PCI. None of the patients had known left ventricular impairment prior to admission.
An out of hospital cardiac arrest (OHCA) prior to presentation was witnessed in 9/12 patients. The left coronary artery was involved in 8/12 patients: 3 left main coronary artery, 4 left anterior descending artery, 1 circumflex artery, the other 4/12 patients had right coronary artery disease.
Survival to discharge was 67% (8/12), one year survival was 42% (5/12), 2/12 patients did not yet reach the one year survival point but are still alive and 1/12 patient died within a year after discharge. All-cause mortality was 42% (5/12) of which mortality on ECMO was 33% (4/12).
Patient related complications occurred in 6/12 patients: 1/12 patient suffered major neurological impairment, 2/12 patients suffered haemorrhage at the cannula site, 2/12 patients had limb ischaemia and 1/12 patient had a haemorrhage elsewhere. There were no malfunctions regarding the VA-ECMO hardware. The median time spent on VA-ECMO was 5 (1–10) days, the median time spent on ICU was 14 (1–68) days and the median time spent in hospital was 23 (1–82) days.
Conclusion: VA-ECMO in pPCI for STEMI has a survival to discharge rate of 67% and even when patients are admitted with an OHCA this outcome is favourable. Complication rate is relatively low and neurological outcome is good. Further research is needed to identify patients most likely to benefit from VA-ECMO treatment in pPCI for STEMI.

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ST elevation myocardial infarction network still faster saves still more lives

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Introduction: Time to reperfusion therapy of patients with ST elevation myocardial infarction (STEMI) is determinant for prognosis. Despite many efforts in the country, total ischemia time (since the onset of symptoms until reperfusion) little has reduced, especially the time between the first medical contact until reperfusion.
Purpose: To evaluate the prognostic impact of myocardial revascularization time in patients with STEMI
Methods: Retrospective study was conducted encompassing all patients admitted for STEMI in a cardiology service of 1/10/2010 to 31/8/2015 treated with angioplasty. These patients were divided into 5 groups depending on the time elapsed from the onset of symptoms until revascularization time (0–3h; 3–6h; 6–12h; 12–24h; >24h). Medical history of patients, data on admission and therapeutic strategies were evaluated. It was performed univariate and multivariate analysis of mortality and hospitalization rates in follow-up of 1 year. For statistical analysis we used SPSS.
Results: In the study period were admitted 1478 patients with STEMI: 501 (34,5%) were revascularized with 0–3h of pain, 506 (34,9%) with 3–6h, 207 (14,3%) with 6–12h, 140 (9,5%) with 12–24h and 97 (6,6%) with <24h.
There was an association with longer revascularization time: female sex (p<0,01), older age (p<0,01), diabetes mellitus (p=0,01), angina pectoris (p=0,01), chronic kidney disease (p=0,01), pulmonary disease (p=0,04), dementia (p<0,01) and hemorrhage (p=0,03).
There was an association with shorter revascularization time: male sex (p<0,01), lower age (p<0,01), smoking (p<0,01), dyslipidemia (p=0,01), myocardial infarction history (p<0,01), coronary angioplasty history (p<0,01), stroke history (p=0,04) and cardiac arrest (p<0,01).
The increase in revascularization time led to a greater number of complications including heart failure (p<0,01), atrial fibrillation (p<0,01), mechanical complications (p<0,01), auriculo-ventricular block (p=0,2), use of non-invasive ventilation (p=0,01) and evolution in Killip class Kimball 2 or higher (p<0,01).
In groups of 0–3h, 3–6h, 6–12h, 12–24h and >24h in-hospital mortality was respectively of 3,2%, 4,9%, 9,2%, 12,9% and 7,2% (p<0,01); the ejection fraction of the left ventricle (LVEF) was 57,8%, 56,3%, 53,3%, 51,1% and 52,3%; hospitalization rate in 1 year follow-up was 10,7%, 19,4%, 24,1%, 23,5% and 25,4% (p<0,01); mortality rate in 1 year follow-up 6,4%, 5,6%, 12,1%, 8,2% and 12,7% (p=0,02).
Conclusions: In patients with STEMI: 1. Longer revascularization time had led to a significant increase in myocardial infarction complication, in-hospital mortality and a significant reduction in left ventricular function assessed by LVEF.
2. In 1 year follow-up patients with longer revascularization time had higher hospitalization rate and higher mortality rate.
3. These results reinforce the need for an investment of physicians and health entities to make the STEMI network "still" faster.

P5595 | BEDSIDE
Gender and quality of life in stable chronic angina patients. Is it still a relevant variable? Results from a National Survey

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Background: Chronic stable angina (CSA) is a highly prevalent condition. However, there is conflicting information about quality of life as assessed by gender.
Purpose: The primary objective of this study was to assess gender differences in CSA patients and in their quality of life (QoL).
Methods: Observational multicentric National survey where 1507 patients with CSA were prospectively and consecutively recruited. Baseline characteristics, Seattle Angina Questionnaire (SAQ), SF-12 and Morisky-Green scores were obtained.
Results: Two hundred seventy-two (18%) of the patients included in the survey were female. Compared with men, women were significantly older, had a similar prevalence of hypertension and diabetes mellitus, but higher rates of heart failure, asthma and hypothyroidism, higher heart rate, but were less smokers, had lower rates of PAD, COPD and prior myocardial infarction. CCS angina classification was worse among women than men (p<0.02), but women had a trend to a lower number of coronary arteries with significant lesions than men (p=0.066), and had less history of coronary revascularisation (79.0% vs 87.0%, p=0.0011). Four out of 5 domains of SAQ were worse in women than men (Table), and also scored worse in all SF-12 questionnaire domains. Morisky-Green showed no difference between genders. Multivariant analysis showed that gender is independently associated with quality of life (worse for women).

Table 1. Seattle Angina Questionnaire domains and gender

Variables	Men (n=1235)	Women (n=272)	p
Physical limitation, mean (SD)	59.80 (25.24)	49.60 (23.84)	<0.0001 (U)
Stability of angina, mean (SD)	70.04 (26.25)	67.65 (28.27)	0.2848 (U)
Frequency of angina, mean (SD)	92.01 (15.76)	89.52 (17.10)	0.0069 (U)
Satisfaction with treatment, mean (SD)	81.93 (14.31)	79.37 (15.05)	0.0082 (U)
Perception of disease, mean (SD)	62.04 (24.15)	56.89 (24.58)	0.0013 (U)

(U): Mann-Whitney-WilcoxonU test.

Conclusions: Despite similar atherosclerotic burden, 12 out of 13 domains in SAQ and SF-12 questionnaires were worse among women than men. Differences remained significant after multivariant adjustment. In spite of all medical progress, women still have worse QoL than men.
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P5596 | BENCH
Comparison of automated quantification and semiquantitative visual analyses for detecting coronary artery disease in patients with stable angina using IQ-SPECT MPI

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Background: Semiquantitative visual analyses is commonly being used for the detection of coronary artery disease (CAD) in nuclear cardiology. The aim of our study is to assess coronary artery disease with automated quantitative total perfusion deficit (TPD), and to detect validity of the automated quantitative and semiquantitative visual analysis by comparing with conventional coronary angiography.
Methods: Patients with suspected CAD underwent two-day 99mTc-sestamibi stress/rest IQ-SPECT myocardial perfusion single photon emission computed to-