

density lipoprotein cholesterol (LDL-C) levels ($p=0.001$). Such duplex scanning indicators as intima-media thickness in systole, intima-media thickness increasing, carotid stenosis degree, significantly different between groups with and without atherosclerotic plaques in carotid arteries ($p=0.001$, $p=0.025$ and $p=0.001$, respectively). Correlation analysis detect statistically significant positive correlations between Lp-PLA2 levels and total cholesterol ($p=0.000$, $p=0.01$, $p=0.001$, respectively); between Lp-PLA2 levels and LDL-C ($p=0.000$, $p=0.03$, $p=0.000$, respectively) in all 3 groups. Besides, it was determined that Lp-PLA2 levels positively correlates with intima-media thickness of carotid arteries increasing in patients of 2 and 3 groups ($p=0.03$ and $p=0.000$, respectively), which is not found in 1 group, where patients were without carotid atherosclerosis.

Conclusion: A significant relationship between elevated Lp-PLA2 and the degree of carotid stenosis, and increased levels of total cholesterol, LDL-C. Elevated levels of Lp-PLA2 in serum, combined with the presence of increasing the degree of carotid stenosis, levels of total cholesterol, LDL-C, can be considered as probable risk factor for cardiovascular events.

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Is stable angina a protective factor? Results of a national registry

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Introduction: Slow progression of atherosclerosis may increase the myocardial tolerance to underlying ischemia, either due to conditioning phenomena or the development of collateral circulation. Thus, the presence of stable angina (SA) prior to the first acute coronary syndrome (ACS) may be a protective factor.

Purpose: This study aims to evaluate the factors associated with the occurrence of SA preceding the first ACS and its impact on prognosis.

Methods: A retrospective, descriptive and correlational study was performed with patients (P) enrolled in a national registry of ACS between 1st October 2010 and 19th January 2017. P with a personal history (PH) of ACS, coronary angioplasty, myocardial revascularization surgery (CABG) and previously anticoagulated were excluded. P were divided into 2 groups, whether or not they had a history of SA. It was evaluated the baseline characteristics and evolution during hospitalization. Univariate (UA) and multivariate statistical analysis (MA) of the factors associated with the occurrence of previous SA was performed. It was also evaluated if the history of SA was associated with higher mortality (M), in-hospital complications (C) (mechanical C, resuscitated cardiac arrest, major bleeding, transfusion, re-infarction, temporary pacemaker (PM) need, heart failure (HF) and cardiogenic shock) or to the combined endpoint (CE) of in-hospital M, non-fatal re-infarction and stroke. SPSS 19.0 was used.

Results: In this period, 11,441 P met the criteria described. 4,049 (27.5%) were female and the mean age was 65±14 years. 1696 (14.8%) had a history of SA. In the UA, the factors associate with SA ($p<0.05$) were female sex; obesity, diabetes; PH of HF, renal failure and chronic obstructive pulmonary disease; higher systolic blood pressure, Killip-Kimbal class >1 and lower haemoglobin value at admission; diagnoses other than ST elevation myocardial infarction; admission to centres without haemodynamic unit and longer periods between the onset of symptoms, 1st medical contact and hospital admission; left ventricular ejection fraction >50%; non-accomplishment of coronary angiography, significant stenosis of any of the epicardial coronary arteries, left main as culprit artery, multivessel disease and indication for CABG. In the MA, independent predictors (IP) of SA were: older age, hypertension, dyslipidaemia, PH of valvular disease (VD), peripheral arterial disease (PAD) and major bleeding, and absence of PH of PM/ICD and stroke. SA was associated with in-hospital HF and major bleeding. There was a negative association with shock, mechanical complication and need for a temporary PM. There were no differences in M or CE.

Conclusions: P with a history of SA had more risk factors and comorbidities. The IP of SA were older age, hypertension, dyslipidaemia, PH of VD, PAD and major bleeding, and absence of a PH of PM/ICD and stroke. SA may be protective against shock, mechanical complication and need for a temporary PM.

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Revascularisation and quality of life in stable chronic angina patients. Is it a relevant variable? Results from a National Survey

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Introduction: Coronary revascularisation has improved during the last decades, both technically and its adjuvant therapy. It is now a safe procedure in patients with suitable coronary anatomy. However, there is little information on quality of life after revascularization and reappearance of anginal symptoms.

Purpose: The aim of this study was to assess reappearance of symptoms after revascularization and its impact on quality of life (QoL) in patients with chronic stable angina (CSA).

Methods: Observational multicentric National survey where 1507 patients with CSA patients were prospectively and consecutively recruited. Baseline characteristics, Seattle Angina Questionnaire (SAQ), SF-12 and Morisky-Green scores were obtained.

Results: 1290 (85.6%) patients had prior revascularization: CABG+PCI 7.2%, CABG 13.9%, PCI 78.9%. Patients with coronary revascularization were more frequently men than women ($p=0.001$), were younger, had more prior myocardial infarction, less history of hypertension, more DM, less kidney disease, higher hemoglobin, lower LDL-C, higher triglycerides, and better heart rate control. Density of angina was similar in both groups. Revascularized patients were treated less frequently with non-dihydropyridinic CCB, nitrates, trimetazidine, but received more ivabradine, ranolazine, antiplatelet treatment, statins and oral antidiabetic treatment. New symptoms resumed in 31.2% of patients after a median of 12 months from revascularization. There was a trend to a worse Morisky Green score among non revascularized patients. SAQ questionnaire yielded worse results in non revascularized patients in all domains but one (similar perception of disease). Standardized SF12 domains showed an impaired physical component, with similar standardized mental component. However, any significant difference between groups disappeared in the multiple regression analysis.

Conclusions: Coronary revascularization is frequent in patients with chronic stable angina. However, reappearance of angina symptoms in also frequent: 31% of patients had new symptoms after a median of 12 months after coronary revascularization. There is no significant difference in QoL in revascularized patients.

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Non-severe aortic stenosis as a predictor of major cardiac events in patients referred for exercise echocardiography

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Patients with aortic stenosis (AS) referred for exercise echocardiography (ExE) might have worse outcome. We aimed to assess the impact of non-severe AS on outcome in patients with a clinically indicated ExE study.

Methods: Retrospective analysis of prospectively collected data on 12,615 patients with a first treadmill ExE performed in our center. Exclusion criteria were ≥moderate aortic regurgitation, significant mitral valve disease, cardiomyopathy, congenital heart disease, and age <18 year-old. Ischemia was defined as a Δ in wall motion score index (WMSI) from rest to exercise; abnormal ExE as exercise WMSI >1.0. End points were major cardiac events (MACE) defined as cardiac death or non-fatal myocardial infarction or aortic valve replacement (AVR), either before any revascularization procedure; and overall mortality.

Results: A total of 330 patients had AS (2.6%; mild in 190, moderate in 140). Patients with AS had worse clinical characteristics (higher age, prevalence of coronary risk factors, % with typical angina, atrial fibrillation, abnormal resting ECG, history of coronary disease, and taking cardiovascular medications) and worse exercise testing characteristics (lower systolic blood pressure and heart rate at exercise, less achieved workload, and more frequency of symptoms and positive ECG) than those without AS. ExE showed more frequently abnormal ExE results and ischemia in those with AS (53% vs. 42%; and 47% vs. 30%; both $p<0.001$). Left ventricular ejection fraction and WMSI at peak exercise were also worse in them (59 ± 14 vs. 62 ± 13 , $p<0.001$; and 1.29 ± 0.39 vs. 1.22 ± 0.34 , $p=0.001$). During follow-up (Median 3.2 years, 25–75th percentiles=0.12–8.0 years) there were 1,394 MACE and 2,575 deaths. The annualized MACE rates were 17.0% in moderate AS, 6.5% in mild AS, and 2.8% without AS ($p<0.001$). After adjustment for clinical characteristics and resting and exercise echocardiography, the presence of AS was an independent predictor of MACE (Hazard ratio [HR]=1.99, 95% Confidence Interval [CI]=1.77–2.24, $p<0.001$). Any of the exercise echocardiography variables increased further the power of the model for predicting MACE: ΔLVEF, peak LVEF, ΔWMSI, ischemia, and abnormal (all $p<0.001$). AS was also an univariate predictor of mortality (HR=1.28, 95% CI=1.13–1.44, $p<0.001$), although it was not after adjustment.

In conclusion, patients with symptomatic non-severe AS have more frequently abnormal ExE studies and are at a higher risk of major cardiac events. The presence of non-severe AS is an independent predictor of events in patients referred for ExE.

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Diagnostic yield of invasive coronary angiography in a UK district general hospital

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Introduction: Invasive coronary angiography (ICA) remains the gold standard for the diagnosis of patients with stable coronary artery disease (CAD) and acute coronary syndromes (ACS). A large American registry in 2010 demonstrated a low diagnostic yield.1 Furthermore, In 2010 UK NICE guidelines recommended that patients with chest pain and high pre-test probability (PTP) of CAD, should go directly to ICA. Cardiac CT and functional imaging tests were recommended for patients with low and intermediate PTP respectively.