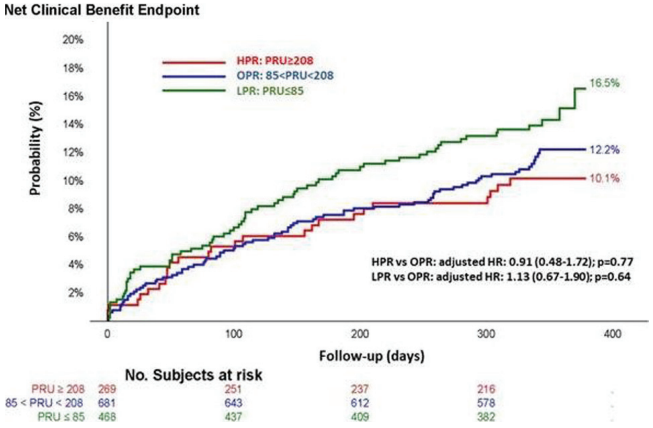
by the VerifyNow P2Y12 test two weeks after coronary stenting. HPR was defined by PRU≥208, LPR by PRU≤85 and optimal platelet reactivity (OPR) by 85
Results: Among the 1,418 patients included, HPR was present in 269 patients (18.9%), OPR was reached in 681 patients (48.0%) and LPR in 468 patients (33.0%). The primary composite endpoint occurred in 9.7%, 11.5% and 14.3% respectively. There was no significant difference in the net clinical benefit between HPR and OPR patients (adjusted HR: 0.91; 95% CI: 0.48–1.72; p=0.77) and between LPR and OPR patients (adjusted HR: 1.13; 95% CI: 0.67–1.90; p=0.64) (Figure). There were no differences in the individual clinical endpoints between the three groups. Receiver operating characteristic curve analysis demonstrated that PRU when used for treatment adjustment has a limited ability to discriminate net clinical benefit, ischemic events or bleeding complications (curve – c index=0.55, 0.51 or 0.59, respectively).



Conclusion: Two weeks after stenting, optimal platelet reactivity was obtained in less than half of the population. The net clinical benefit of these patients was not different from that of patients with HPR and LPR who had treatment adjustment.

P1723
When will be appropriate time for P2Y12 inhibitors dose de-escalation?

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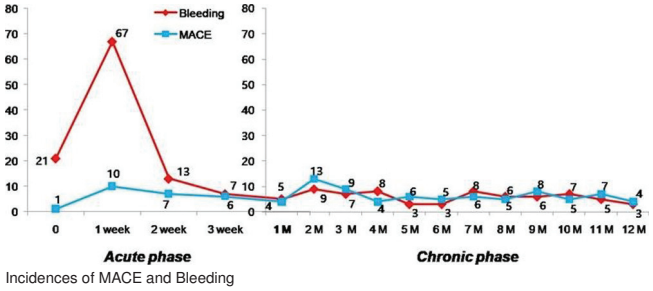
Background: The optimal duration of dual antiplatelet therapy (DAPT) after percutaneous coronary intervention (PCI) with drug eluting stents (DESs) is unclear. Because prolonged DAPT is associated with higher bleeding risk and health care costs, establishing optimal DAPT duration is important.
Objectives: We sought to compare patterns of clinical outcomes between short- (1- months) and long-term (1-year) DAPT post-DES placement.
Methods: This study included 903 patients who were admitted with non-ST-elevation or ST-elevation myocardial infarction requiring PCI. 903 consecutive patients were treated with maintenance dose DAPT (75 mg/day clopidogrel, or 10 mg/day prasugrel, or 180 mg/day ticagrelor, all on top of 100 mg aspirin). Major cardiovascular events (MACEs) (all-cause death, myocardial infarction, urgent revascularization, stroke) and major bleeding as defined by the Bleeding Academic Research Consortium (BARC) classification ≥3 were collected at 1-month and 1-year post PCI.
Results: There were a total of 113 (12.5%) 1-month major bleeding and 65 (7.2%) 1-year major bleeding.1-month and 1-year MACEs occurred in 28 (3.1%) and 72 (8.0%) patients respectively. 1-month compared with 1-year DAPT after PCI resulted in strongly increased rates of major bleeding (p<0.001), but there were not significantly different between 1-year major bleeding and MACEs (p=0.53).



Incidences of MACE and Bleeding

Conclusion: Major bleeding rates of DAPT appeared to be higher in short-term duration than in long-term duration. De-escalation strategy of P2Y12 inhibitors could be considered within a month, possibly between 1 to 2-weeks period.

PREDICTION OF ACUTE CORONARY SYNDROMES PROGNOSTICS

P1724
PRESTO score: simple score for early discharge of patients with ST-elevation myocardial infarction treated with primary percutaneous coronary angioplasty

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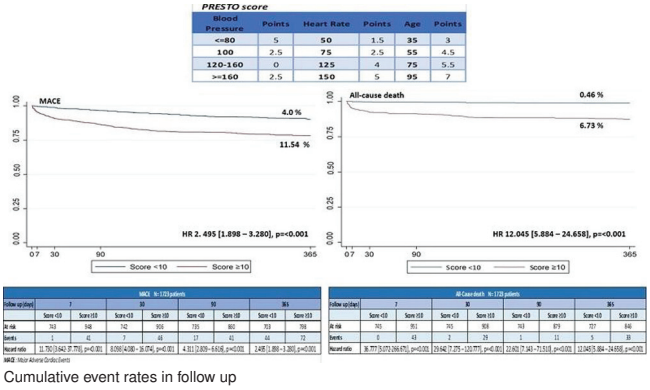
Background: Early discharge (ED) for low-risk patients treated with primary coronary angioplasty is safe and cost-effective. Risk scoring systems for ED recommended in the guidelines are sophisticated and time-consuming for use in daily practice.
Purpose: Develop and validate a simple scoring system using a reduced number of variables to predict major cardiovascular adverse events (MACE) (all-cause mortality, myocardial infarction, and unplanned repeat revascularization).
Methods: All the data of the patients in our register of primary angioplasty enrolled between January 2008 and December 2016 was analyzed and 3 simple clinical variables were selected: age, heart rate (HR), and systolic blood pressure (SBP) upon arriving at cath lab. We developed a logistic model to predict MACE and all-cause mortality at 7 days, 30 days and 365 days, the results were simplified into a score table; patients with <10 points were considered as low-risk and ≥10 points were considered as high risk. Finally, a survival analysis was performed and our new score was compared to the GRACE score (high (≥140), low risk (<140)).
Results: 1723 patients were classified into 2 groups based on the PRESTO score: 745 patients (43.23%) were identified to have a low-risk. The low-risk group was composed by a younger and overweight male population with a higher number of active smokers. Thus, diabetes mellitus and hypertension were significantly higher in the high-risk group. On admission the low-risk group presented with significantly lower Killip class IV, normal left ventricle ejection fraction (LVEF), and a lower GRACE score. The cumulative incidence of MACE and all-cause death was lower in patients with a score <10, as depicted by Kaplan-Meier survival curves. The adjusted risk for MACE and all-cause death was higher in patients with ≥10 points than in patients with <10 points, with a hazard ratio (HR) 11,730 (95% confidence interval [95% CI] 3.642–37.778, p≤0.001) for MACE and for all-cause death HR 36,777 (95% CI 5.072–266.671, p≤0.001) at 7 days follow-up, also being significant to 30, 90 and 365 days. The area under de ROC curve (AUC) of the PRESTO score for predicting MACE was 0.681, with a sensitivity (SE) of 90.2% and a specificity (SP) of 45.9%. The AUC for predicting all-cause death was 0.718 (SE of 98.0% and SP of 45.7%). We compared the ability of our score with the GRACE score for predicting MACE and all-cause death. There were no differences between the GRACE and the PRESTO ROC curves for MACE (p=0.708 at 7 days, p=0.192 at 30 days, p=0.639 at 90 days), but significant differences were found in favor to the proposed model for predicting all-cause death (p=0.005 to 7 days, p≤0.001 to 30 days, p≤0.001 to 90 days).



Cumulative event rates in follow up

Conclusions: The PRESTO score is a simple and accurate tool for identifying low-risk patients for early discharge after primary angioplasty, with a better prediction ability for detecting all-cause death compared to the GRACE score.

P1725
Short and long term prognostic value of admission glycosylated hemoglobin and glucose in nondiabetic patients with acute myocardial infarction

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