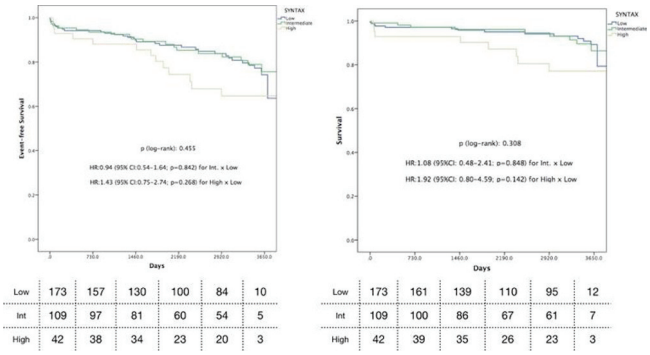
score, respectively. The Kaplan-Meier curves showed no significant difference of MACCE (p=0.455) or survival (p=0.308). In the multivariate analyzes only age was found to bea significant predictor of MACCE (HR: 1.03 per/year; p=0.048).



Low	173	157	130	100	84	10
Int	109	97	81	60	54	5
High	42	38	34	23	20	3

Low	173	161	139	110	95	12
Int	109	100	86	67	61	7
High	42	39	35	26	23	3

Conclusion: In this sample, the SYNTAX score was not a predictor of long-term outcomes, in terms of MACCE or survival, after elective CABG.

P6362
Comparison of the predictive value of contemporary risk scores for CIN development in patients with acute myocardial infarction undergoing primary percutaneous coronary intervention

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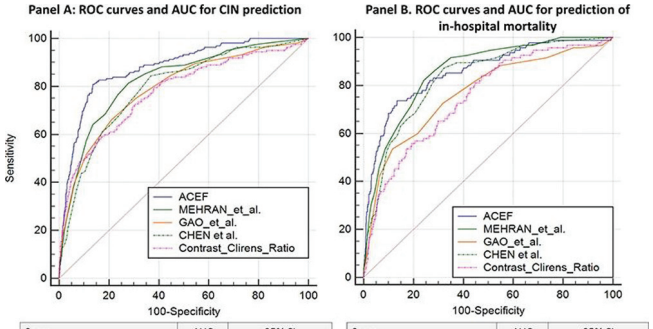
Background: Contrast induced nephropathy (CIN) is well known complication following contrast media application and in patients with acute myocardial infarction (AMI) undergoing primary percutaneous coronary intervention (PCI) development of CIN is related to worse outcomes. Therefore, prediction of CIN is of paramount importance and in this regard several risk scoring models were developed.
We aimed to compare the prognostic value of 5 validated risk scores for CIN following primary PCI.
From a prospective database in a period from January 2009 up to December 2017 we identified 5024 consecutive pts who underwent pPCI for AMI and in whom 5 validated risk-scores for CIN were calculated: 1) Mehran; 2) Gao; 3) Chen; 4) Age, serum creatinine (Cr) and ejection fraction (ACEF); 5) Contrast to creatinine clearance ratio. The prognostic accuracy of the 5 scores for CIN, and in-hospital all-cause mortality was assessed using the c-statistic for discrimination and DeLong method for comparison of receiver operator characteristic (ROC) curves. CIN was defined as absolute increase in serum Cr $\geq$0.5 mg/dl.
In predominantly male population (71%), aged 61±11.9 years, CIN occurred in 3.2% of patients, while overall In-hospital rate of death was 1.89%. Patients who developed CIN had higher in-hospital mortality compared to patients without this complication (29.6% vs. 1.2%; p<0.0001). All risk scores had relatively high predictive values for CIN (c-statistic: 0.777 to 0.879) and also performed well for prediction of in-hospital mortality (c-statistic: 0.750 to 0.857). The ACEF risk score had better discrimination and calibration for CIN (p<0.001 vs. all; Figure 1, Panel A), while In-hospital mortality was predicted with high accuracy by Mehran and Chen score as well, compared to other models (Figure 1, Panel B).



Score	AUC	95% CI
ACEF	0.879	0.870 to 0.888
Mehran_et_al. ¥	0.827	0.816 to 0.837
Gao_et_al. ¥	0.792	0.780 to 0.803
Chen_et_al. ¥§	0.793	0.782 to 0.804
Contrast_Clirens_Ratio ¥§	0.777	0.765 to 0.789

¥ p<0.001 significance vs. ACEF; § p<0.05 significance vs. Mehran et al.; p>0.05 not marked

Score	AUC	95% CI
ACEF	0.857	0.847 to 0.867
Mehran_et_al.	0.858	0.848 to 0.868
Gao_et_al. ¥§	0.770	0.758 to 0.782
Chen_et_al. ¤	0.833	0.822 to 0.843
Contrast_Clirens_Ratio ¥§δ	0.751	0.739 to 0.763

¥ p<0.001 significance vs. ACEF; § p<0.05 significance vs. Mehran et al.; ¤ p<0.05 significance vs Gao et al.; δ p<0.001 significance vs. Chen et al.; p>0.05 not marked

Figure 1

Conclusion: Risk scores for predicting CIN perform well in stratifying the risk of CIN and in-hospital death in patients with AMI undergoing pPCI. The ACEF score, the simplest to calculate with only 3 variables, appears to have the highest prognostic value for CIN development following pPCI for acute myocardial infarction.

CORONARY REVASCULARISATION

P6363
Real world experience with Reducer implantation for refractory angina treatment

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Background: Refractory angina is defined as chronic chest pain, due to severe coronary artery disease (CAD) despite optimal medical therapy and with no option for interventional or surgical revascularization. Coronary sinus (CS) Reducer (Neovasc Inc., Richmond B.C., Canada) implantation emerged as a novel therapeutic treatment to improve quality of life and to relieve symptoms in these patients. To date, only a single randomized clinical trial and three observational studies demonstrating safety and efficacy are available.
Purpose: Aim of this study is to assess clinical efficacy of the Reducer device in a real-world setting.
Methods: This is a multicentre, observational retrospective registry involving Italy, Israel, The Netherlands, and Belgium. Patients' baseline clinical characteristics, Canadian Cardiovascular Society (CCS) angina severity class, and Seattle Angina Questionnaire (SAQ) scores at baseline and follow-up were recorded.
Results: Between March 2010 and December 2017, a total of 207 patients underwent Reducer implantation procedure. In two patients the procedure was aborted due to unsuitable CS anatomy. No cases of periprocedural serious adverse events were reported. Patients were 67.6±10.5 years old, 140 (68.3%) were male, with a high prevalence of CAD risk factors, 34 (20.1%) had chronic kidney disease. A total of 113 (55.1%) had a previous myocardial infarction, 152 (74.1%) a previous CABG, 172 (83.9%) a previous PCI. All suffered from severe refractory angina (CCS class 3.15±0.58) with low scores at the baseline SAQ. Mean number of anti-ischemic drugs prescribed was 2.3±0.9.
A median of 11 (range: 0–73) months of follow-up was available for the 205 implanted patients. A significant reduction in mean CCS was observed at follow-up: 1.89±1.10 vs. 3.17±0.56 (p<0.001), with 160 (78.0%) patients showing at least 1 CCS class reduction. This translated in improvement in all of the SAQ domains scores at follow-up: 61.8±20.8 vs 43.2±17.8 for physical limitation, 66.6±26.9 vs 36.3±20.5 for angina stability, 67.0±20.9 vs 45.2±22.1 for angina frequency, 69.0±17.8 vs 52.3±21.8 for treatment satisfaction, 52.1±20.4 vs 25.8±16.7 for quality of life (p<0.001 for all). These benefits allowed a significant reduction in the number of anti-ischemic drugs prescribed: 2.17±0.95 vs 2.33±0.93 (p=0.004). Twenty (9.8%) deaths occurred at follow-up, with 4 (2%) ascertained cardiac-related, and 38 (18.5%) patients were subsequently hospitalized due to angina. There were no device-related deaths.
Conclusion(s): In our multicentre, real-world experience (the largest reported to date), Reducer implantation in patients with refractory angina was safe and effective in terms of reduction of symptoms and improvement of quality of life at mid-term follow-up. Interestingly, the rate of responder patients reported was around 80%, confirming the findings of previous studies.

P6364
Effect of percutaneous coronary intervention on duration of rhythm conversion in late onset STEMI patients (>12 hours) presented with high degree AV block

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Background: High degree atrio-ventricular (AV) block is a common complication in patients with ST elevation myocardial infarction (STEMI). In late presentation of STEMI patients (>12 hours onset) presented with high degree AV block, the effect of percutaneous coronary intervention (PCI) in converting the rhythm and shortening the duration of rhythm conversion is still debatable.
Purpose: To assess the effect of PCI on duration of rhythm conversion in late onset STEMI patients who were presented with high degree AV block.
Methods: We conducted a retrospective cohort study of late onset STEMI patients who were presented with high degree AV block during the period of January 2011 until January 2017 in a tertiary care cardiac hospital. The main outcome was the duration of rhythm conversion.
Results: There were 91 subjects enrolled in this study that consist of 52 subjects in the PCI group and 39 subjects in the non PCI group. There were 43 subjects (82,7%) with duration of conversion $\leq$96 hours in PCI group and 6 subjects (15,4%) with duration of conversion $\leq$96 hours in the non PCI group. Multivariate analysis showed that PCI strongly associated with duration of rhythm conversion [odds ratio 70,7 (confidence interval 95%: 9,16 - 545,63); p=0,001].