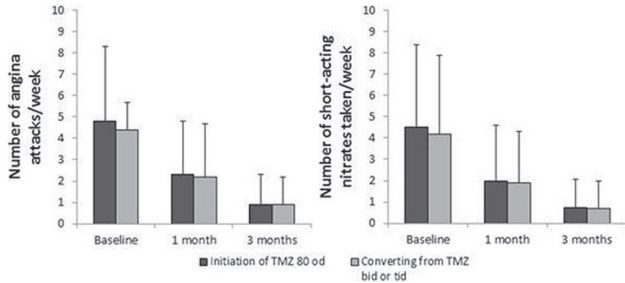


icant intergroup differences. Medication adherence was improved in both groups compared to baseline. In the Initiation Group, 54% of patients declared complete adherence at M3 (vs 25% at baseline), 42% were minor noncompliant (vs 40%) and 3% were noncompliant (vs 34% at baseline); in the Switch Group 59% of patients declared complete adherence (vs 21% at baseline), 39% were minor noncompliant (vs 41%) and 3% were noncompliant (vs 38% at baseline). Overall efficacy of TMZ 80 mg od was rated by physicians as “very good” (68% in Initiation Group, 70% in Switch Group), “good” (31% in Initiation Group, 29% in Switch Group), “moderate” (1%) in both groups and “poor” (<1%) in both groups. Overall tolerability of TMZ 80 mg od was rated by physicians as “very good” (75%), “good” (25%) or “moderate” (<1%) in both groups.



Number of angina attacks and SAN

Conclusion: In this prospective non-interventional study over a 3-month period in daily clinical practice in stable angina patients with persistent symptoms despite therapy, both initiation of TMZ 80 mg od or converting patients from TMZ bid or tid effectively reduced angina attacks and short-acting nitrate consumption.

Funding Acknowledgements: The study was funded by Servier, Russia

P6440
Mid-term outcomes of second-generation drug-eluting-stent implantation for left main coronary artery disease compare with first-generation drug-eluting-stent

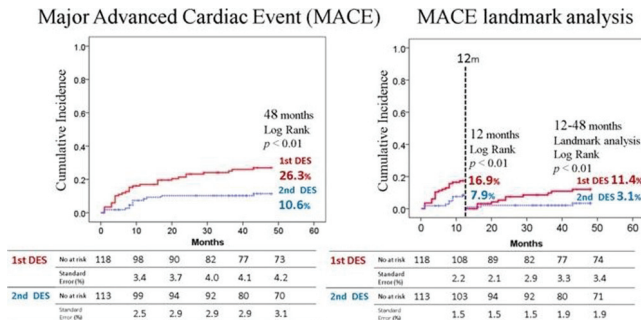
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Background/Introduction: There are some short-term reports about drug-eluting-stent (DES) implantation to left main coronary artery (LMCA) disease. But the reports of mid-term outcomes of Second-generation DES were received limited study.

Purpose: To evaluate the mid-term efficacy of second generation DES to LMCA disease

Methods: Between April 2004 and July 2013, DES implantation to the LMCA was performed to 231 lesions in our single center. There were divided Second-generation DES from First-generation DES, and compared by Kaplan-meier method with log-rank test. Primary endpoint was Major Adverse Cardiac Event (MACE) at 4-year follow-up. MACE is defined as composite endpoints of all cause death, myocardial infarction, cerebrovascular disease, and target lesion revascularization. We also analyzed the outcomes between 1-year and 4-year, using Land-mark analysis. Predictors of MACE were evaluated with cox-proportional hazard model retrospectively.

Result: Second-generation DES were implanted to 113 lesions and First-generation DES were 118 lesions. 86.6% was single stent, and 70.6% was distal LMCA. Baseline characteristics were similar. At the 4-year follow-up, MACE was significantly less observed in Second-generation DES (10.6% vs 26.3%, $P < 0.01$). Landmark-analysis after 1-year revealed that Second-generation DES also reduced mid-term MACE. Event rate is shown in the Figure. Cox regression multivariate analysis revealed that First-generation DES [(hazard ration (HR) 2.494, 95% confidence interval (CI): 1.264–4.923; $p = 0.008$)], estimated Glomerular Filtration Rate less than 30 ml/min/1.73m² (HR 5.294, 95% CI: 2.431–11.528; $p < 0.001$), T-stent (HR 2.494, 95% CI: 1.557–7.213; $p = 0.002$), and cerebrovascu-



MACE included all cause death, myocardial infarction, cerebrovascular event, and target lesion revascularization. MACE at 4-year and landmark analysis

lar disease (HR 3.312, 95% CI: 1.364–8.043; $p = 0.008$) were independent predictors of MACE at 4-year.

Conclusions: Second-generation DES is better than First-generation DES in the short-term, and that has consistently continued to 4-year follow-up in LMCA disease. First-generation DES was one of the independent predictors of MACE at 4-year.

P6441
Impact of admission during ON vs OFF hours on mortality in unselected ST-elevation myocardial infarction patients referred in percutaneous coronary intervention centers:insights from the ORBI registry

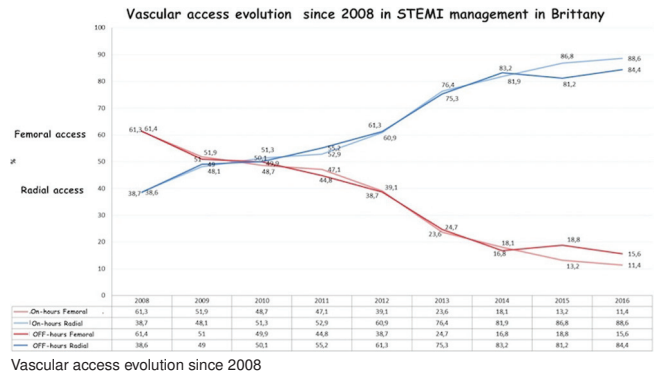
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Background: The effect of admission during OFF-hours on patient’s outcome in ST Segment Elevation Myocardial Infarction (STEMI) remains controversial as a strategy for reperfusion between primary Percutaneous Coronary Intervention (pPCI) and fibrinolysis is chosen. We aimed to evaluate the impact of time of admission on all cause mortality in unselected STEMI patients referred to pPCI centers.

Methods: Data from 10850 consecutive patients admitted in the nine interventional cardiology centers in Brittany for STEMI in the 24 first hours following the beginning of symptoms were collected in a network registry. Characteristics and clinical outcome of patients admitted during ON-hours (Monday through Friday 8h am–6h30 pm) were compared to OFF-hours patients (night shifts, weekends and non-working holidays). Clinical outcome was all-cause in hospital mortality, major bleeding, and mechanical complications in STEMI.

Results: A total of 4644 confirmed STEMI patients (57.2% were admitted during OFF-hours and 6206 (42.8%) patients during ON-hours. Baseline characteristics were overall well balanced between the two groups including features of high risk STEMI such as ventricular fibrillation (3.7% vs 3.6% $p = 0.8$), cardiogenic shock (6.9% vs 7.6% $p = 0.1$), mechanical complications (3.2% vs 2.7%, $p = 0.2$), excepted the anterior myocardial infarction more prevalent in OFF period (42.4% vs 39.9% $p = 0.01$). The population was older in the ON group (63.7 vs 62.2, $p < 0.0001$). Time from symptom onset to First Medical Contact (FMC) were slightly longer for patients presenting during on-hours (97 min vs 95 min $p < 0.03$). Time from FMC to angiography was longer during OFF-hours compared to ON-hours (100 min vs. 92 min $p < 0.0001$). Time from arrival in the PCI center to angioplasty was higher in the OFF period (40 mn vs 38 mn, $p < 0.0001$). The reperfusion treatment was different between the two periods, with more fibrinolysis and less PCI in OFF group (PCI: 76.7% vs 79.6%, $p < 0.0001$; Fibrinolysis: 11.4% vs 8.9%, $p < 0.0001$).

The use of radial access (RA) was uniform in both group (66.8% and 66.6%; $p = 0.9$) and not different whatever the admission time. The use of radial access (RA) increased meaningfully from 2008 for the two periods (RA OFF group: 84.4% vs 38.6%, RA ON group: 88.6% vs 38.7%) There was no impact of admission time on in-hospital all cause mortality in the entire population (5.3% vs 5.4% $p = 0.7$), and on the Timi 3 flow for the patients treated with primary angioplasty (On group: 94% vs 94.3%, $p = 0.5$). The bleeding complications were similar in both groups (2.5% vs 2.6%, $p = 0.8$).



Conclusions: Even though the time of reperfusion is slightly longer in patients admitted for STEMI during off-hours, no difference was observed in the PTCA technique and success rates as well as in the in-hospital mortality and bleeding rates. A long term patient follow-up would be necessary before definite conclusions.