transfusions and unfavorable outcomes, preoperative anaemia might become a new target to improve results after cardiac surgery in adults with implementation of substitution therapies.

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Emergency endovascular repair for acute traumatic thoracic aortic transection
X. Pu, Y.I. Ning, X.Y. Huang, L.J. Huang on behalf of Intervention Therapy of P3970 | BEDSIDE
peripheral artery disease endovascular repair according to combined presence of coronary or Clinical outcomes of patients with abdominal aortic aneurysm after P3971 | BEDSIDE
Acute traumatic thoracic aortic transection is a life-threatening condition resulting in a sudden deceleration. Concurrent injuries can make treatment prioritization difficult and require early recognition and prompt intervention. Surgical replacement of aorta is associated with high rates of morbidity and mortality and in this view endovascular treatment seems to be a safe and effective alternative.

Objective: The aim of this study was to analyze our experience of emergency thoracic endovascular aortic repair (TEVAR) in patients with acute traumatic thoracic LSA occlusion.

Methods: From January 2014 to December 2016, a total of 35 acute thoracic aortic transection patients were brought to our hospital. Patient demographics including age, injury detail and preoperative Computed Tomography Angiography (CTA) were analyzed. Emergency TEVAR was performed and postoperative follow-up consisted clinical and CTA at discharge, 1, 3 and 6 months and yearly thereafter.

Result: 1. Totally 35 patients were enrolled. The median age was 42y (range, 20–71y), 31 of 35 patients (88.6%) were men. 30 patients had been involved in vehicle accidents, while the other 5 patients had fallen from heights. All patients had concomitant injuries.

2. The aortic transection was diagnosed by CTA, and in all cases the transection segment was located at the distal of the origin of left subclavian artery (LSA). 3. 1 patient died before he was transferred to catheter room. 34 (97.14%) patients underwent TEVAR procedure successfully. The percutaneous femoral access was performed for stent delivery in all patients, the mean proximal aortic diameter was 23.7±5.5mm, the mean length of injured segment was 44.9±7.36mm. A single stent graft implantation was sufficient to exclude the injured segment in all cases. The median proximal diameter of stent-graft was 30mm (range 26–32mm), which oversized 22.7±6.55%.

Conclusion: Acute traumatic thoracic aortic transection is extremely fatal. TEVAR is a safe and effective treatment option for acute thoracic aortic transection. The experiences of our center are: first, percutaneous access is preferred to TEVAR in ordinary aortic dissection; third, a balloon should be prepared to TEVAR is a safe and effective treatment option for acute thoracic aortic transection; second, the oversize of the stent graft should be larger than TEVAR in ordinary aortic dissection; third, a balloon should be prepared to avoid aortic rupture during procedure.

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Clinical outcomes of patients with abdominal aortic aneurysm after endovascular repair according to combined presence of coronary or peripheral artery disease
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Background: In patients with abdominal aortic aneurysm (AAA), atherosclerotic disease such as coronary artery disease (CAD) or peripheral artery disease (PAD) are frequently combined. We sought to investigate impact of concomitant CAD or PAD on clinical outcomes in patients treated with endovascular aortic aneurysm repair (EVAR).

Methods: Patients were divided into group A (n=166), patients without combined CAD or PAD, group B (n=196), patients with combined CAD, but without PAD, and group C (n=113), patients with combined PAD regardless of CAD. The primary endpoint was the accumulating rate of major adverse cardiovascular and cerebrovascular event (MACCE), a composite of all-cause death, myocardial infarction (MI) and stroke.

Results: The prevalence of CAD and PAD was 55.8% (265/475) and 23.8% (113/475), respectively. Mean follow-up duration was 40.2±25.3 months. At 3 years, there were 36 MACCEs (28 all-cause deaths, 7 aneurysm-related deaths, 1 MI, 8 strokes). The incidences of stroke and MACCE were significantly different among the groups (MACCE; A 5.6% vs. B 9.5% vs. C 16.7%, P=0.021; Stroke; A 2.4% vs. B 3.1% vs. C 5.2%, P=0.025). AAA patients with combined PAD showed significantly higher rates of stroke (P<0.008) and MACCE (P=0.008) compared with those without combined CAD or PAD. Combined PAD and previous stroke were independent predictors of MACCE.

P3972 | BEDSIDE
Are morphologic findings of aortic intramural haematomata predictors of mortality in acute phase?
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Background: Only type A intramural haematomata (IMH) is accepted as indication of invasive treatment for this pathology in practice guidelines. Nevertheless, other factors as maximum aortic diameter (MAD), intimal disruptions (ID) or haematomata thickness do not have well-established recommendations.

Objective: To determine morphologic predictive factors of aortic mortality in acute phase of IMH.

Methods: One hundred and forty-three patients with an IMH were included prospectively in a clinical and imaging protocol: 36 (25%) type A and 107 type B (75%). Clinical and morphological parameters as MAD, initial haematomata thickness and the presence of ID were collected. ID was defined as the presence of an intimal defect in the aortic wall ~3mm.

Results: Aortic mortality during hospitalization was 6% (9 cases), 5 type A (14%) and 4 type B (4%) IMH; p=0.03. Development of ID (21% vs 4%; p=0.03) and MAD (54.4±14.5 vs 44.7±11.2mm; p=0.015) were related with aortic mortality in acute phase. Other parameters as initial haematomata thickness, age or invasive treatment were not associated with mortality. Basal MAD was a good predictor of mortality in acute phase (area under the curve=80%, p=0.014; excluding patients who received invasive treatment). A basal MAD>47mm showed a sensitivity of 100% and a specificity of 69% while MAD>55mm demonstrated a sensitivity of 94% and a specificity of 91% for aortic mortality during hospitalization.

Conclusions: Development of an ID and a MAD>55mm in acute phase of IMH should be considered as strong indications for invasive treatment. Patients with MAD>47mm should be carefully follow-up as a group of risk.