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Applicability of the COMPASS clinical trial: Analysis of the prospective French registry COPART

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Background Lower extremity-peripheral artery disease (LE-PAD) is associated with an increased risk of cardiovascular death (CV death) and represents a heavy burden in cardiovascular morbidity and mortality. The COMPASS trial demonstrated an interest in giving rivaroxaban 2.5 mg twice-daily plus acetylsalicylic acid for the prevention of atherothrombotic events in patients with high risk PAD or coronary artery disease. COPART (COhorte de Patients ARTériopathes) is the only French registry of consecutive hospitalized patients admitted for LE-PAD management, with a one-yean follow-up.
Aim The aim of the analysis was to estimate the percentage of patients with LE-PAD eligible to a treatment with rivaroxaban 2.5 mg twice daily plus a low dose of ASA once daily and describe their characteristics and prognosis.
Results Among 2,513 patients included in the COPART registry 1,472 (58.6%, CI_{95} 56.7%—60.5%] fulfilled the COMPASS criteria. The main reason for non -inclusion in the analysis was the need of double antiplatelet or anticoagulant therapy. Mean age was 70.5 years in the whole sample (69.3 in COMPASS-like patients), 75.1% of the patients were men (73.9% of COMPASS patients), 36.7% had a previous history of CAD (32.9% in COMPASS-like patients), 37.5% had renal failure (33.7% in COMPASS-like patients), 70% presented with Rutherford IV-V-VI (66% of COMPASS-like), 37.2% presented with hemodynamically proven critical limb ischemia (34.1% of COMPASS-like patients). Incidence rates of all cause death were 18.2 in the whole sample and 12.1/100 person-years among COMPASS-like patients. A total of 1,092 patients (49.8%) had at least one complication during the one-year follow-up period (543, 44.4%, COMPASS-like patients) (Fig. 1). Male gender, diabetes, cardiac failure, anemia at index hospitalization, and severe stage PAD (rest pain, ulcer or gangrene, acute ischemia) were associated with an increased one-year risk of complication in both groups.

Table a: Incidence rates of complications (per 100 person-years) during the one-year follow-up

Incidence rates of	Patients alive at hospital discharge with at least one day of follow-up N=2,191	
	Whole sample n=2,191	COMPASS-like patients N=1,223
All complications*	68.9 / 100 person-yrs	59.1 / 100 person-yrs
All cause death	18.2 / 100 person-yrs	12.1 / 100 person-yrs
MACE	2.97 / 100 person-yrs	1.93 / 100 person-yrs
MI	2.06 / 100 person-yrs	1.83 / 100 person-yrs
Stroke		
Amputation Total	20.8 / 100 person-yrs	17.0 / 100 person-yrs
Major	12.2 / 100 person-yrs	8.76 / 100 person-yrs
Minor	10.1 / 100 person-yrs	9.25 / 100 person-yrs
Revascularization		
Coronary artery	2.39 / 100 person-yrs	1.65 / 100 person-yrs
Carotid artery (endarterectomy)	0.32 / 100 person-yrs	0.18 / 100 person-yrs
Lower limb artery	29.3 / 100 person-yrs	29.7 / 100 person-yrs

* All cause death, MACE (MI, or stroke), major bleeding, major or minor amputation, or revascularization (coronary, carotid or lower limb artery). However, since data of occurrence was not available for major bleedings, incidence rates for one-year complications does not include major bleedings

Fig. 1

Disclosure of interest Subvention Bayer.

https://doi.org/10.1016/j.acvdsp.2019.09.021

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Which treatment for post-infectious myocardial infarction? An observational study from RICO survey

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Background Acute infection is a frequent trigger of myocardial infarction (MI). However, whether post-infectious MI require specific acute care is still unknown.
Purpose We aimed to evaluate the prognostic impact of coronary angiography (CA) and MI drugs on cardiovascular (CV) and all-cause mortality in post-infectious MI patients.
Methods Among 4573 consecutive MI patients from the RICO Survey in intensive care units (ICU), 466 (10%) patients were diagnosed with a concurrent acute infection at admission. A Cox regression model was built including traditional MI prognosis factors and CV therapeutics, to evaluate their prognostic impact on one-year CV mortality.
Results Among the 466 post-infectious MI patients, (mean age 78y), 313 (67%) had a respiratory tract infection, including 163 acute bronchitis (35%), 150 (32%) pneumonia and 150 (33%) had non-respiratory infection. Among the 365 patients who underwent CA, an atherothrombotic event (type 1 MI) was found in 130 (36%) patients. At one year follow-up, 108 patients were dead (23%), of whom 68 (15%) from CV cause. In Cox regression multivariable analysis, acute pneumonia was associated with a twice-higher risk of CV mortality (OR95% CI = 2.31(1.16—4.60)), when compared with other infections. After adjustment on confounders, aspirin (OR 95%CI = 0.23(0.11—0.52)), beta-blockers (OR95%CI = 0.34 (0.16—0.72)), and Angiotensin Converting Enzyme inhibitors (ACEi) (OR95%CI = 0.38(0.18—0.81) where associated with a lower CV mortality, whereas CA (OR95%CI = 0.98 (0.53—1.80)) or statins (OR95%CI = 0.78 (0.34—1.78)) were not significant estimates. Similar results were found after exclusion of type 1 MI.
Conclusions In this first prognostic study in post-infectious MI in ICU, 1-Y CV mortality was very high (15%), especially after pneumonia. Moreover, aspirin, beta-blockers and ACEi, but not CA or statins, were associated with a lower risk of mortality.
Disclosure of interest The authors declare that they have no competing interest.

https://doi.org/10.1016/j.acvdsp.2019.09.022

Thursday, January 16th, 2020

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Determinants of extrahospital delays in case of management of STEMI

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Background In a previous quality control assessment of the management of STEMI in our centre—a tertiary centre in a rural area—we

observed a decrease in intrahospital delays over time (2004→2013) from 98→39 minutes (median) but unchanged extrahospital delays (203—220 minutes).

Aim To elucidate the determinants of these long extrahospital delays, 181 patients, undergoing PCI for STEMI (2013—2017) in our centre, were carefully interviewed. The first medical contact (FMC) allowed to assess 2 periods: onset of symptoms—FMC (period 1) and FMC—diagnosis (period 2). Results are given as mean values (median).

Results In 36%, the FMC took place via the general practitioner (GP). Period 1 was associated with the type of FMC (GP: 210 ± 294, median = 79 min/EM call: 78 ± 114, median = 43 min/direct hospital admission: 222 ± 44, median = 115 min), the moment of symptoms onset (0—4 am: 198 ± 192, median 142 min/8—12 am: 96 ± 126, median 60 min), age (70—80 y: 262 ± 324, median 120 min/50—60 y: 198 ± 438, median 63 min) and the distance to our PCI centre expressed in minutes by car (< 30′: 108 ± 156, median = 60 min/ > 60′: 216 ± 288, median = 116 min). Period 2 was depending on the type of FMC (GP: 234 ± 600, median 56 min/EM call: 31 ± 29, median 22 min/direct hospital admission: 25 ± 55, median 10 min).

Conclusion In our local experience, FMC via the GP in case of STEMI is a major determinant for a longer extrahospital delay and should therefore be discouraged.

Disclosure of interest The authors declare that they have no competing interest.

https://doi.org/10.1016/j.acvdsp.2019.09.023

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Incidental coronary artery lesions on cardiac CT performed before AF ablation

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Purpose Assess the incidence of coronary artery disease found on cardiac CT performed as part of the AF pre-ablation assessment.

Method This monocentric retrospective study included 350 patients between 01/01/2013 and 01/06/2017. Exclusion criteria are known coronary artery disease, AF during cardiac CT not allowing coronary analysis, poor injection of contrast medium. Coronary lesions assessed with CT scan were classified as absence of lesion, plaque, stenosis < 50% and ≥ 50%.

Results Three hundred and fifty patients received cardiac CT, 58 of whom had known ischemic heart disease, coronary arterioles were immeasurable in 90 patients, 69 of whom were in FA, and 10 patients with missing data were excluded. 192 patients (Mean Age 59 yo; 30.2% females) had coronary artery assessment. The incidence of ischemic coronary artery disease was 5.2%. Coronarography was performed in 3.6% of patients and stenting was performed in 1.8% of cases and only in patients with stenosis ≥ 50%.

Conclusion The incidence of ischemic coronary artery disease was 5.2% among patients undergoing CT scan before AF ablation.

Disclosure of interest The authors declare that they have no competing interest.

https://doi.org/10.1016/j.acvdsp.2019.09.024

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Frequency, management and outcomes of patients with stable coronary artery disease eligible for COMPASS. An analysis of the CLARIFY Registry

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Background A previous analysis of the REACH Registry showed that 52.9% of stable vascular patients were eligible to COMPASS. However, data regarding eligibility to COMPASS in CAD patients from real life practice are scarce.

Purpose To describe the proportion, management and outcomes of patients eligible to COMPASS and to compare patients excluded, eligible, and who did not meet the ''enrichment criteria'' (COMPASS Excluded, Eligible and Not Included).

Methods We used the CLARIFY Registry (> 30.000 stable CAD patients). According to COMPASS protocol, patients with a REACH bleeding risk score (BRS) > 10, heart failure, severe renal failure, need for dual antiplatelet therapy (DAPT), or anticoagulant therapy were excluded. Then, COMPASS inclusion criteria were applied: CAD patients had to be > 65 years, if younger, have documented atherosclerosis, or at least two enrichment criteria (current smoker, diabetes, GFR < 60 mL/min, or non lacunar ischemic stroke). Ischemic outcome: CV death, MI, or stroke. Bleeding outcome: bleeding leading to admission, transfusion, or haemorrhagic stroke.

Results A total of 15.185 patients had comprehensive data allowing precise assessment of eligibility, from which 43.1% had at least one exclusion criteria, 23.1% did not have enrichment criteria and 33.9% were eligible. The vast majority were excluded due to high bleeding risk (62.7% needing DAPT, and 52.7% for high REACH BRS). Ischemic and bleeding outcome (100 patients/year) were 2.3 [2.1—2.5] and 0.5 [0.4—0.6] respectively for COMPASS-Eligible, 3.0 [2.8—3.2] and 0.6 [0.5—0.7] for COMPASS-Excluded and 1.2 [1.0—1.4] and 0.2 [0.2—0.3] for COMPASS-Not Included.

Conclusion In a large registry of stable CAD patients, approximately one of three patients was potentially eligible for adjunction of low-dose rivaroxaban to aspirin, and remains at high risk of ischemic outcome. COMPASS-Excluded had the worse ischemic and bleeding outcomes and represent a group in need of improved therapy.

Disclosure of interest Bourse de recherche Abbot/Frais de voyage Bayer et AlviMedica.

https://doi.org/10.1016/j.acvdsp.2019.09.025