

In multiple linear regression analysis, diabetes, age and obesity are important risk factors that influence the presence of aortic calcifications. Diabetes, hypercholesterolemia, heredity, and smoking are significant risk factors that influence the presence of coronary stenosis. And two independent predictive risk factors for coronary stenosis are identified: aortic calcifications and hypercholesterolemia. The presence of aortic calcifications is the most significant predictor with OR = 102.040 (CI: [9.764 - 1066.429]).

Conclusion The discovery of aortic calcifications on chest x-ray or echocardiography in a relatively young subject should therefore be an incentive to search for other potentially threatening arterial diseases, such as coronary artery disease.

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

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Management of left main coronary artery disease. A real-life experience of a Tunisian center

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Background In patients with left main coronary artery (LMCA) stenosis, PCI with drug-eluting stents may be an acceptable alternative to CABG. However, data from African subcontinent are lacking. **Purpose** We sought to evaluate trends in treatment strategies of LMCA disease over time in Sahloul University Hospital and to compare early and long-term adverse outcomes of each therapeutic option.

Methods From 2005 to 2016, 260 patients with unprotected LMCA were included. In total, 102 patients underwent Surgery, 109 patients underwent PCI and 49 patients were medically treated.

Results Over time, the proportion of patients treated with PCI rather than CABG increased substantially. Patients treated with PCI had more anterior ST-segment elevation myocardial infarction (MI) and cardiogenic shock at presentation compared to CABG group. More patients treated with CABG had multivessel disease, more distal LMCA bifurcation and higher SYNTAX scores. All the other baseline variables were similar. After a follow-up of 39 ± 26 months in PCI group and 52 ± 38 months in CABG group, there were no differences between PCI and CABG, at the adjusted analysis, in the rate of myocardial infarction (MI) (HR: 1.75; 95% CI: 0.55 to 5.50; $P=0.33$), cerebrovascular accidents (CVA) ($P=0.69$), and the composite of MACCE (HR: 1.04; 95% CI: 0.59 to 1.83; $P=0.88$). Compared to PCI group, CABG group has a higher all-cause mortality ($P=0.017$) driven exclusively by an elevated incidence of operative mortality (13.7% vs. 6.4%; HR: 0.08; 95% CI: 0.017 to 0.43; $P=0.003$). Nevertheless, long-term advantage of CABG over PCI was the less need for repeated revascularization (HR: 3.1; 95% CI: 1.26 to 8.12; $P=0.014$). Medically treated patients produced a four-year all cause death rate of 44%.

Conclusion Revascularization therapy of LMCA stenosis have evolved remarkably over the last decade in our faculty. PCI and CABG show comparable safety. However, repeat revascularization is more common after PCI.

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Agatston calcium score, CHA2DS2-VASc and HAS-BLED in patients before atrial fibrillation ablation

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Background Clinical scores of thrombo-embolism risk (CHA2DS2-VASc) and hemorrhagic risk (HAS-BLED) have been developed to characterize the patients with non-valvular atrial fibrillation. These scores have been defined in part with clinical risk factors of atherosclerosis. Before their ablation, a coronary computed tomography angiography enables to determine the Agatston calcium score (coronary artery calcium score) which is a atherosclerosis marker.

Purpose In this study, we tried to find out a link between the Agatston calcium score and the CHA2DS2-VASc, as well as between the Agatston calcium score and the HAS-BLED.

Methods In total, 344 atrial fibrillation subjects were included in our observational and retrospective study between January 1st, 2013 and January 1st, 2017, in the same institute. All of these patients had undergone a coronary computed tomography angiography.

Results Three hundred and seventeen patients were included in this study: 233 men (73.5%) and 84 women (26.5%), with an average age of 60.4 years. Agatston calcium score was significantly higher in the subjects with CHA2DS2-VASc score ≥ 2 ($P < 0.00001$); for men ($P < 0.00000001$ for a CHA2DS2-VASc ≥ 2) and for women too ($P = 0.03$ for CHA2DS2-VASc ≥ 3).

This link is also found between the Agatston calcium score and the HAS-BLED score ≥ 2 ($P < 0.0000000001$) (Fig 1).

Conclusion This study shows a strong link between the atherosclerosis marker determined by CT (coronary artery calcium score), the thrombo-embolism risk score (CHA2DS2-VASc) and the hemorrhagic risk score (HAS-BLED) determined by clinical elements in patients with non-valvular atrial fibrillation.

		Score CHA2DS2-VASc			P
		0	1	≥ 2	
Agatston calcium score	0	30 (44,1%)	35 (42,2%)	37 (22,3%)	<0,00001
	1 à 99	25 (36,8%)	27 (32,6%)	40 (24,1%)	
	100 à 399	10 (14,7%)	6 (7,2%)	28 (16,8%)	
	400 à 999	1 (1,5%)	8 (9,6%)	29 (17,5%)	
	≥ 1000	2 (2,9%)	7 (8,4%)	32 (19,3%)	

Fig. 1 Comparison between CHA2DS2-VASc and Agatston calcium score.

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Predictors and prognosis of spontaneous reperfusion in acute myocardial infarction

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Background ST elevation myocardial infarction (STEMI) remains one of the most frequent emergencies, requiring an as early as possible reperfusion that may result, in some cases, from physiological fibrinolysis.

