Conclusion The percentage of uncovered struts of the SYNERGY stent was 21,48% at 1 month post angioplasty in the context of ACS. This result provides a logical rationale for decreasing the duration of dual antiplatelet therapy at 1 month in patients at high risk of bleeding.

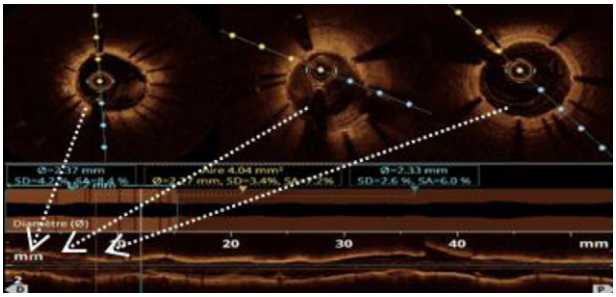

Fig. 1 OCT at 1 month of DES SYNERGY implantation, on the proximal, intermediate and distal portions, attesting well endothelialization.

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

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JE19-168

Thrombolysis Versus Primary Percutaneous Coronary Intervention For ST-segment Elevation Myocardial Infarction In Elderly Patients

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Background Only few studies reported the outcomes of thrombolysis among elderly patients with ST-segment elevation myocardial infarction (STEMI), which results in a controversial benefit-risk ratio and a lower usage rate of thrombolysis in this population.
Objectives The aim of the present study was to compare efficacy and safety of thrombolysis therapy with primary percutaneous coronary intervention (p-PCI) in patients aged $\geq$ 70 years old.
Methods Data from 2841 patients (mean age: 78.1 $\pm$ 5.6 years, female: 36.1%) included in a prospective multicenter registry, and who underwent either thrombolysis therapy (N = 269) or p-PCI (N = 2572), were analyzed. The primary endpoint was in-hospital major adverse cardio-vascular events (MACE) defined as the composite of all-cause mortality, non-fatal MI, stroke and definite stent thrombosis (ST). Secondary endpoints included all-cause death, BARC 3 or 5 major bleeding, net adverse clinical events (NACE) and the development of in-hospital Killip class III or IV heart failure. Propensity-score matching and conditional logistic regression were used to adjust for confounders.
Results Within the matched cohort, rates of MACE was not statistically different between the thrombolysis (N = 247) and pPCI (N = 958) groups, (11.3% vs. 9.0% respectively, OR: 1.25, 95% CI: 0.81—1.94; P = 0.31). Secondary endpoints were comparable between groups at the exception of a significant difference for the development of Killip class III or IV heart failure in favor of the thrombolysis group (3.3% vs. 9.3%, OR: 0.38, 95% CI: 0.18—0.79; P = 0.01) (Fig 1).
Conclusion Thrombolysis may be a safe and effective strategy in selected elderly patients, which may reduce the development of severe heart failure without a higher major bleeding rate.

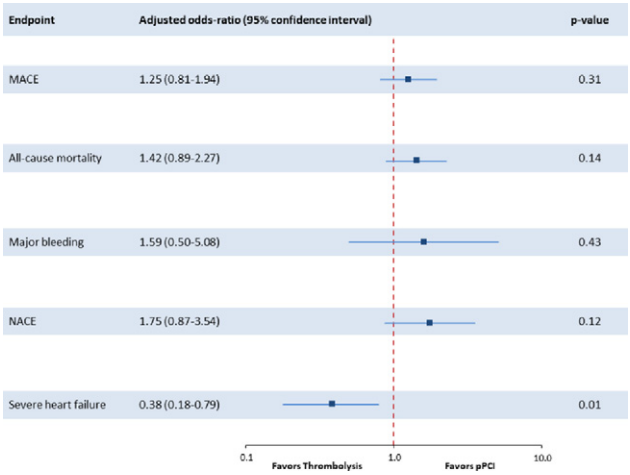

Fig. 1 MACE: Major adverse cardio-vascular events; NACE: Net adverse clinical event; pPCI: Primary percutaneous coronary intervention.

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

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JE19-274

Relationship between aortic calcifications and coronary stenosis

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Background Aortic sclerosis is an active phenomenon, significantly associated with vascular and coronary atherosclerosis and shares the cardio-vascular risk factors.
Purpose Correlation between the presence of aortic button calcifications on chest X-ray, Calcifications of the ring and aortic sigmoids on transesophageal echocardiography (TOE) and angiographic coronary stenosis.
Methods Prospective Study: 150 patients (male-female sex ratio: 0.89, mean age 53 $\pm$ 2 years) were randomly recruited with the only requirement the need for a coronary assessment. The maximum delay between chest x-ray, TOE and coronarography was 1 month.
Results Chest aortic button calcifications were found in 44.66%, calcifications of the ring and aortic sigmoids at ETO in 44%. Eighty patients had coronary artery stenosis. Among them: ''single-vessel'' 25%, 35% ''two-vessel'' and 40% ''Triple vessel''. There is a significant relationship between the presence of Chest aortic button calcifications coronary stenosis with OR = 7.85 (CI = [3.51 - 17.85]). And a significant relationship between the presence of calcifications of the ring and aortic sigmoids and the existence of coronary stenosis with OR = 7.85 (CI: [3.70 - 16.50]).

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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JE19-395

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.

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

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JE19-461

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 ($P < 0.000000001$ 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 ($P < 0.00000000001$) (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.

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

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JE19-483

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.