

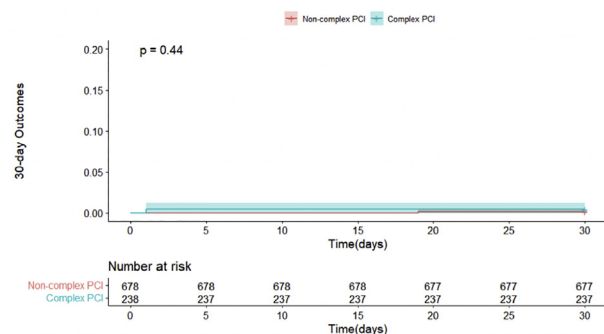
technique. The primary outcome was a composite of all-cause death, spontaneous myocardial infarction, target vessel revascularization, or rehospitalization of cardiovascular cause within 30 days after index procedure.

**RESULTS** Of 916 patients with SDD after PCI, 238 (26.0%) underwent complex PCI. The mean age of the patients was 61.9 years, and 740 (80.8%) were men. Except for 1 case, all other patients underwent PCI via the radial approach, and 913 (99.7%) procedures involved intracoronary imaging for PCI guidance. Complex PCI patients required more stents ( $2.4 \pm 1.1$  vs  $1.2 \pm 0.4$ ;  $P < 0.05$ ) and more contrast ( $236.6 \pm 96.0$  mL vs  $158.1 \pm 60.0$  mL;  $P < 0.05$ ). The primary outcome at 30 days was not significantly different between the complex and noncomplex PCI groups (0.4% vs 0.1%;  $P > 0.99$ ). There were no significant differences in the rates of death, myocardial infarction, target vessel revascularization, rehospitalization of cardiovascular cause, and major bleeding event between groups.

Table 1. 30-day Clinical Outcomes of Same-day Discharge after PCI

	Overall (N=916)	Complex PCI (N=238)	Non-complex PCI (N=678)	P value
<b>30-Day Outcomes</b>				
Primary composite outcome	2 (0.2%)	1 (0.4%)	1 (0.1%)	>0.99
Death	0 (0.0%)	0 (0.0%)	0 (0.0%)	>0.99
Myocardial infarction	1 (0.1%)	0 (0.0%)	1 (0.1%)	>0.99
Repeat revascularization	1 (0.1%)	0 (0.0%)	1 (0.1%)	>0.99
Rehospitalization of cardiac cause	2 (0.2%)	1 (0.4%)	1 (0.1%)	>0.99
Major Bleeding	1 (0.1%)	0 (0.0%)	1 (0.1%)	>0.99

Fig. 1. Kaplan-Meier Event Curves of the Primary Composite Outcomes at 30-days



**CONCLUSIONS** SDD was safe and effective after successful PCI for complex lesions, including left main, bifurcation, and multivessel disease. Further investigation is warranted to determine a reliable decision pathway for SDD after complex PCI.

**CATEGORIES CORONARY:** Complex and Higher Risk Procedures for Indicated Patients (CHIP)

**THROMBUS AND THROMBECTOMY**

Abstract nos: 201-205

**TCT-201**

**Linkage of Diabetic Status With Thrombogenic Indices and Its Prognostic Implication in Patients Undergoing Percutaneous Coronary Intervention**

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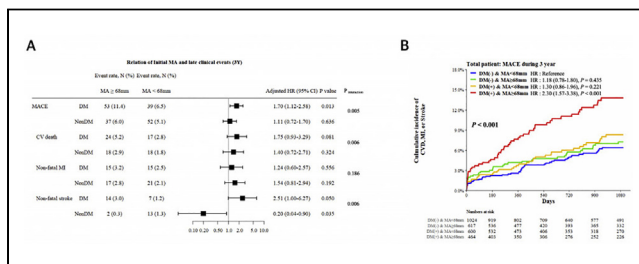


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**BACKGROUND** The linkage of diabetic status with thrombogenicity and its prognostic implications have been poorly explored in patients with significant coronary artery disease (CAD).

**METHODS** We enrolled patients with CAD undergoing percutaneous coronary intervention with viscoelastic properties of clot formation assessed by thromboelastography (n = 2,705). Major adverse cardiovascular events (MACE) were defined as a composite of cardiovascular death, myocardial infarction, or stroke up to 3 years.

**RESULTS** Patients with diabetes (n = 1,064 [39.3%]) showed higher platelet-fibrin clot strength (PFCS) (maximal amplitude  $66.7 \pm 7.8$  mm vs  $65.4 \pm 7.2$  mm;  $P < 0.001$ ) and similar fibrinolytic activity (lysis at 30 minutes  $1.1\% \pm 2.4\%$  vs  $1.0\% \pm 2.3\%$ ;  $P = 0.130$ ) compared with those without diabetes. PFCS level increased linearly according to glycated hemoglobin up to 7.0, and their relationship then reached a plateau. In a multivariable analysis, high PFCS (defined as  $\geq 68$  mm) was significantly associated with MACE occurrence (HR: 1.59; 95% CI: 1.15-2.20;  $P = 0.005$ ). High PFCS did not increase the risk for MACE in patients without diabetes (HR: 1.11; 95% CI: 0.72-1.70;  $P = 0.636$ ), whereas its prognostic implication was significant in patients with diabetes (HR: 1.70; 95% CI: 1.12-2.58;  $P = 0.013$ ) ( $P_{\text{interaction}} = 0.005$ ). Patients with diabetes with high PFCS showed the highest risk for MACE compared with other groups ( $P < 0.001$  for all).



**CONCLUSIONS** PFCS is closely related to the degree of diabetes control. In addition, its prognostic implication is different according to diabetic status.

**CATEGORIES OTHER:** Diabetes, Lipid Disorders, and Risk Factor Management

**TCT-202**

**Pre-Ballooning in High Thrombus Laden STEMIs: An Independent Predictor of Slow Flow/No-Reflow in Patients Undergoing Emergent Percutaneous Coronary Revascularization**

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**BACKGROUND** Distal embolization due to microthrombus fragments formed during preballooning is considered a possible mechanism of slow flow (SF) or no-reflow (NR). The aim of this study was to compare the incidence of intraprocedural SF or NR during primary percutaneous coronary intervention (PCI) in patients with high thrombus burden (grade  $\geq 3$ ) with and without preballooning for culprit lesion preparation.

**METHODS** This study included patients with high thrombus burden (grade  $\geq 3$ ) who underwent primary PCI. Propensity-matched cohorts of patients with and without preballooning in a 1:1 ratio were compared for the incidence of intraprocedural SF/NR

**RESULTS** A total of 765 patients with high thrombus burden who underwent primary PCI were included in this study. The mean age was  $55.75 \pm 11.54$  years, and 78.6% patients (n = 601) were men. Preballooning was done in 346 patients (45.2%). The incidence of intraprocedural SF or NR was significantly higher (41.3% vs 27.4%;  $P < 0.001$ ) in the preballooning cohort. The incidence of intraprocedural SF/NR also remained significantly higher in the preballooning cohort (41.3% vs 30.1%;  $P = 0.002$ ) for the propensity-matched non-preballooning cohort, with a relative risk of 1.64 (95% CI: 1.20-2.24). Also,