Abstract: P157

Clinical outcome in very elderly patients referred for percutaneous coronary intervention for acute coronary syndromes

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Topic(s):
Acute Coronary Syndromes – Epidemiology, Prognosis, Outcome

Citation:

Funding Acknowledgements:
none

Introduction: Acute coronary syndrome (ACS) is an increasing health issue in Europe, also due to aging of population. Percutaneous coronary intervention (PCI) is the most important therapy for patients presenting with ACS and it has been showed to be safe even in elderly patients. Poor data are available in very elderly (= 85 years old) patients undergoing PCI for ACS.

Purpose: To evaluate clinical outcome in very elderly patients with ACS treated with PCI.

Methods: We retrospectively analysed consecutive patients = 85 years old admitted to our institution for ACS and treated with PCI.

Results: From May 2009 to January 2018, 242 patients were admitted to our department for ACS and treated with PCI. Median age was 87.7 [86.0-90.0], 91 (37.6%) were male, 25.3% had diabetes and 15.5% chronic kidney disease (CKD). Eighty patients (33.1%) had ST-elevation myocardial infarction (STEMI), the remaining non ST-elevation ACS. Overall mortality was 56.2% during a median follow up of 388 [73-1176] days; none of the patients died during the procedure. The univariable analysis showed that age, CKD, presentation as STEMI, Killip class III or IV were associated to an increased mortality. At the multivariable analysis, only CKD (HR 2.34, 95% CI 1.46-3.77, p < 0.001) and diabetes (HR 1.59, 95% CI 1.04-2.42, p = 0.033) resulted as independent predictors of death (Table 1). Figure 1 reports the survival curves in patients with and without CKD and in those with and without diabetes.

Conclusions: In very elderly patients with ASC PCI is feasible and effective, however overall long-term mortality is high. The main independent predictors of mortality in our study were CKD and diabetes.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Median/frequency</th>
<th>HR (95%CI) unadj</th>
<th>p</th>
<th>HR (95%CI) adj</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>87.7 [86.0-90.0]</td>
<td>1.06 [1.01-1.13]</td>
<td>0.043</td>
<td>1.05 [0.98-1.12]</td>
<td>0.152</td>
</tr>
<tr>
<td>Male</td>
<td>91 (37.6)</td>
<td>1.11 [0.78-1.57]</td>
<td>0.551</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>24.2 [21.9-27.3]</td>
<td>1.01 [0.96-1.06]</td>
<td>0.677</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>46 (25.3)</td>
<td>1.69 [1.13-2.53]</td>
<td>0.011</td>
<td>1.59 [1.04-2.42]</td>
<td>0.033</td>
</tr>
<tr>
<td>Hypertension</td>
<td>181 (74.8)</td>
<td>1.13 [0.67-1.90]</td>
<td>0.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CKD</td>
<td>28 (15.5)</td>
<td>2.41 [1.55-3.77]</td>
<td>&lt;0.001</td>
<td>2.34 [1.46-3.77]</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>STEMI</td>
<td>80 (33.1)</td>
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<td>0.005</td>
<td>1.18 [0.79-1.75]</td>
<td>0.419</td>
</tr>
<tr>
<td>Killip class III-IV</td>
<td>28 (14.4)</td>
<td>1.91 [1.18-3.09]</td>
<td>0.008</td>
<td>1.58 [0.90-2.78]</td>
<td>0.112</td>
</tr>
<tr>
<td>Radial Access</td>
<td>161 (66.5)</td>
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<td>0.407</td>
<td></td>
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</table>

BMI = body mass index; CKD = chronic kidney disease; STEMI = ST-elevation myocardial infarction; CM = contrast medium.
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---|---|---|---|---|---
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Hypertension | 181 (74.8) | 1.13 [0.67–1.90] | 0.64
CKD | 28 (15.5) | 2.41 [1.55–3.77] | <0.001 | 2.34 [1.46–3.77] | <0.001
STEMI | 80 (33.1) | 1.62 [1.15–2.28] | 0.005 | 1.18 [0.79–1.75] | 0.419
Killip class III–IV | 28 (14.4) | 1.91 [1.18–3.09] | 0.008 | 1.58 [0.90–2.78] | 0.112
Radial Access | 161 (66.5) | 0.86 [0.61–1.22] | 0.407
CM amount | 110 [80–160] | 1.00 [0.99–1.01] | 0.637

BMI = body mass index; CKD = chronic kidney disease; STEMI = ST-elevation myocardial infarction; CM = contrast medium.