

in 99.2% of patients. No procedural mortality, stroke, guidewire kink, or ventricular perforation were reported.

CONCLUSION The results of this study showed the safety and efficacy of the SavvyWire for TAVR. The use of this device could help to minimize interventions during the procedure and improve the clinical decision-making after THV deployment.

CATEGORIES STRUCTURAL: Valvular Disease: Aortic

Session: Interventional Pharmacology in CAD: DAPT, SAPT, and Anticoagulation - I TCT-354

The Clinical Impact of Dual Antiplatelet Therapy Score Combined With P2Y₁₂ Reactivity Unit on East Asian Patients Who Received Drug-Eluting Stent Implantation: PTRG-DES Consortium

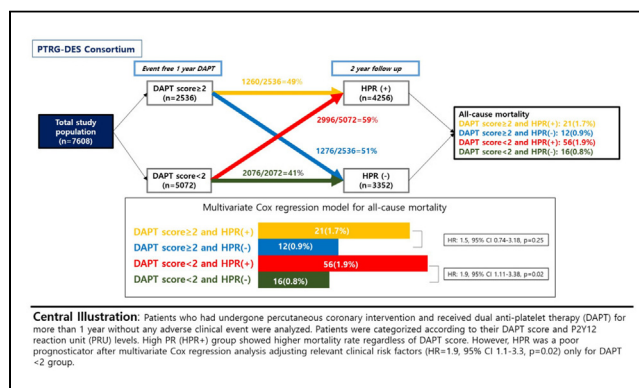


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BACKGROUND Our aim is to assess the clinical implication of a P2Y₁₂ reactivity unit combined with dual antiplatelet therapy (DAPT) score in East Asian patients who received percutaneous coronary intervention (PCI) along with DAPT therapy over 1 year.

METHODS Among the 13,160 patients from the nationwide multi-center PTRG-DES registry, patients who had received PCI along with DAPT therapy over 1 year without any clinical events from July of 2003 to August of 2018 were enrolled. The patients were divided into HPR(+) and HPR(-) groups by a P2Y₁₂ reactivity unit cutoff value of 208 U. These patients were classified according to their DAPT score (DAPT score ≥ 2 and DAPT score < 2). The primary endpoint was all-cause mortality from 12 months to 30 months after index PCI.

RESULTS The HPR(+) group showed higher all-cause mortality compared with the HPR(-) group by multivariate Cox regression analysis (1.8% vs 0.8%; HR: 1.629; 95% CI: 1.046-2.538; $P = 0.031$). Among the patients with a DAPT score < 2 , the HPR(+) group consistently showed significantly higher all-cause mortality than the HPR(-) group (1.9% vs 0.8%, HR: 1.937; 95% CI: 1.108-3.387; $P = 0.02$). However, it was not statistically significant in patients with a DAPT score ≥ 2 (1.7% vs 0.9%; HR: 1.533; 95% CI: 1.108-3.387; $P = 0.25$) after multivariate Cox regression analysis.



CONCLUSION In patients who were event free with DAPT therapy for 12 months after index PCI, HPR(+) was associated with higher all-cause mortality from 12 months to 30 months, especially in patients with a low DAPT score. Combination of HPR and DAPT score can stratify patients who are likely to have an increased risk of all-cause mortality.

CATEGORIES CORONARY: Pharmacology/Pharmacotherapy

Session: Cardiogenic Shock and Out-of-Hospital Cardiac Arrest - II TCT-355

The Weekend Effect on Cardiac Arrest Admissions—Is There Room for Improvement? An Insight From the National Inpatient Sample



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BACKGROUND Numerous studies have shown unfavorable clinical outcomes for patients admitted on weekends, especially in those with cardiovascular complications. This can be attributed to limited access to cardiac catheterization and other interventions due to reduced staffing levels in hospitals during weekends. In this context, we aimed to evaluate the clinical outcomes of cardiac arrest patients admitted over weekends using a nationwide cohort analysis.

METHODS We queried the National Inpatient Sample database between 2015 and 2019. We included patients with cardiac arrest as an admission index using the ICD-10-CM and then further stratified them to weekend vs weekday admissions. The 2 groups were then compared using multivariate regression models. The primary outcomes included in-hospital mortality and MACCE. Statistical analysis was performed using STATA version 17.

RESULTS Among the 50,440 weighted hospitalizations recorded for cardiac arrest during the study period, 27% of admissions occurred over the weekends. Patients admitted on weekends had higher rates of comorbidities, such as complicated hypertension, diabetes, prior CABG, peripheral vascular disease, and renal failure. Moreover, patients admitted on weekends had higher rates of in-hospital mortality (adjusted OR [aOR]: 1.106; 95% CI: 1.03-1.18), MACCE (aOR: 1.13; 95% CI: 1.05-1.21), stroke (aOR: 1.31; 95% CI: 1.05-1.63), and acute myocardial infarction (aOR: 1.11; 95% CI: 1.005-1.23). Rates of major bleeding (aOR: 1.18; 95% CI: 0.98-1.42) and AKI (aOR: 1.05; 95% CI: 0.99-1.12) were similar between both groups.

CONCLUSION Patients experiencing cardiac arrest and being admitted on weekends exhibited poorer clinical outcomes and higher