ate whether baseline SXscore was associated with contrast induced nephropathy (CIN) after primary percutaneous coronary intervention (p-PCI) in patients with ST-elevation myocardial infarction (STEMI). Secondary aims were to investigate the relation of the severity of CIN to long term prognosis.

**Methods:** We retrospectively enrolled 1893 patients with STEMI treated by p-PCI. We prospectively followed up the patients for a mean duration of 45 months. Those presenting with 3rd degree atrioventricular block (AVB) were grouped according to the development of no nephropathy (grade 0; n=1634), mild nephropathy (grade 1; n= 153) or severe nephropathy (grade 2; n=106).

**Results:** SXscore was significantly higher (19.4±5.9 vs 15.6±4.8; p<0.001) in patients with CIN (grade 1 and 2) compared to those without CIN. SXscore was higher in patients with grade 2 CIN compared to those with grade 1 CIN (18.6±5.7 vs 20.7±5.9; p<0.001). In the multivariate analysis, SXscore was identified as an independent predictor of CIN (for one unit increment, OR: 1.06, 95% CI: 1.01 - 1.14, p=0.006). At long-term follow-up, death (p<0.001), stroke (p<0.006), reinfection (p=0.024) and permanent HD requirement (p<0.001) were most frequent in grade 2 nephropathy group. HD was associated with very high in-hospital (60%) and long-term (83.3%) mortality rates.

**Conclusions:** SXscore is an independent predictor of development and severity of CIN after p-PCI. CIN is associated with poor prognosis during both early and late postinfarction period.

**References:**

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**Prognostic significance of narrow fragmented QRS complex on admission ECG in patients with ST elevation myocardial infarction**

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**Purpose:** The aim of this study was to assess the prognostic value of the presence of narrow fragmented QRS complexes (fQRS) (<120 ms) on admission electrocardiogram for predicting in-hospital major adverse cardiovascular events (MACE) in patients with ST elevation myocardial infarction (STEMI).

**Methods:** Two hundred and ninety-six patients, who were admitted with STEMI to coronary care unit between 2006 and 2012, were included in this retrospective study. Patients were divided into two groups according to absence or presence of narrow fQRS on admission ECG. fQRS (27%) and non-fQRS (73%) groups. Primary clinical end-point was total mortality and/or hemodynamic instability and/or electrical instability (sustained ventricular tachycardia or ventricular fibrillation).

**Results:** Patients with fQRS had significantly lower ejection fraction at discharge than non-fQRS group (37±11 vs. 42±13; p<0.003). Cardiac mortality (20.0% vs. 5.5%, p=0.058), hemodynamic instability (62.5% vs. 13.8%, p<0.001) and electrical instability (42.5% vs. 18.5%, p<0.05) were higher in the fQRS group compared with the non-fQRS group. In multivariate analysis; fQRS, anterior MI, age ≥65 years and GRACE score (>137) were substantially improved the predictive ability of primary end-points with higher odds ratio (OR;7.3; p<0.001).

**Conclusion:** These results indicate that presence of narrow fQRS on the admission ECG is an independent predictor of mortality and major adverse cardiovascular events in STEMI. The prognostic importance of fQRS was incremental to clinical factors.

**References:**

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**Prognostic implications of atrio-ventricular block in patients undergoing primary coronary angioplasty in the stent era**

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**Purpose:** The appearance of conduction disorders, in particular atrioventricular block (AVB), in patients undergoing primary coronary angioplasty (PCI) after ST segment elevation myocardial infarction (STEMI) is associated with high mortality. Previous studies have analyzed the implications of AVB in patients with acute coronary syndrome treated with fibrinolysis. However, the implications of AVB in patients with PCI treated with primary angioplasty have not been sufficiently studied.

**Methods:** We analyzed 913 consecutive patients with STEMI treated with primary angioplasty. All clinical, electrocardiographic and angiographic variables were collected prospectively.

**Results:** AVB was documented in 115 patients (12.6%). On admission, it was present in 70 (7.7%), and persistent at hospital discharge in 36 (3.9%). Within these, first-degree AVB was identified in 29 (3.2%); second-degree in 27 (3%) and third-degree in 73 (8%). The appearance of AVB was more frequent in women, elderly, hypertensive, diabetic, with worse functional class (Killip class >2) and with higher incidence of inferior infarctions (p<0.05). AVB in general and, more specifically, third-degree AVB was associated with a higher mortality (20.5% vs. 5.7%; p<0.001), reoccurring infarction (8.2% vs. 3.6%; p<0.06) and a greater incidence of cardiogenic shock (33.3% vs. 14%; p<0.001). Interestingly, these events were more frequent in patients with persistent AVB at hospital discharge than in patients with transient AVB or present AVB on admission. In the multivariate analysis, persistent AVB at hospital discharge proved to be an independent predictor of cardiovascular events (death and reoccurring infarctions), not the rest of AVB.

**Conclusions:** The appearance of AVB in patients who underwent primary angioplasty is associated with a worse prognosis while in hospital. This risk is particularly high in patients with persistent AVB, whereas present AVB on admission and transient AVB are associated with better prognosis.