

Objective: To evaluate the quality of vitamin K antagonists (VKA) control in very elderly patients in geriatrics setting and to assess the characteristics associated with VKA control.

Design: National cross-sectional survey.

Settings: Patients aged 80 years or more, hospitalized or institutionalized in rehabilitation care or long-term settings and who were treated by VKA.

Participants: 2633 patients were included. Clinical and biological information was collected through a standardized questionnaire.

Measurements: Time in therapeutic range (TTR) was computed according to the Rosendall's method.

Results: The mean (SD) age was 87.2 (4.4) years and 72.9% of the patients were women. Atrial fibrillation represented 71.4% of the indications for VKA therapy. The most prescribed VKA was Fluindione (64.9%). The mean (SD) TTR was 57.9 (40.4)%. After backward logistic regression (TTR < 50% vs. $\geq 50\%$), poorer VKA control was associated with the indication for VKA treatment (prosthetic heart valve vs. AF; OR=4.86; 95% CI=2.87-8.24), the type of VKA used (Fluindione vs. Warfarin; OR=1.26; 95% CI=1.03-1.54, and Acenocoumarol vs. Warfarin; OR=1.68; 95% CI=1.01-2.79), a history of INR > 4.5 (yes vs. no; OR=1.37; 95% CI=1.11-1.69), antibiotics use (yes vs. no; OR=1.63; 95% CI=1.10-2.41) and falls (≥ 2 falls during the past year vs. < 2; OR=1.26; 95% CI=1.01-1.56). Conversely, a longer test interval was associated with better VKA control (≥ 9 vs. < 9 days; OR=0.41; 95% CI=0.34-0.49).

Conclusion: Overall VKA control remains insufficient in very old patients. Poorer VKA control was associated with taking VKA for a prosthetic heart valve, the use of other VKAs than warfarin, a shorter interval between INR tests, and a history of overcoagulation, antibiotics use and falls.

Conclusions: Patients with a history of IHD do not call earlier than IHD naïve patients when they are confronted with symptoms of AMI. Cardiologist should spend more time to educate their coronary patients to recognize symptoms of AMI.

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Patient education after acute myocardial infarction: cardiologists should do a better job! The FAST-MI 2010 registry.

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Background: A shorter time delay between onset of symptoms and first call to medical attention would be expected in patients with a history of ischemic heart disease (IHD), compared with patients not known to have IHD, either because they have already experienced an AMI or because their GPs/cardiologists would have educated them to recognize symptoms of AMI. The aim of this study was to determine whether time to first call for a STEMI differed between patients with or without history of coronary artery disease.

Methods and Results: FAST-MI 2010 is a nationwide French registry that included 4169 patients with AMI at the end of 2010 in 213 centres. These comprised 2364 STEMI patients. Factors correlated with time to first call were assessed, with a specific emphasis on previous history of IHD (IHD+ n=382), compared with patients without history of IHD (IHD- n=1982). Time from onset to first call (TOFC) was 245±453 min (median 75 min) in IHD+ patients vs 246±431 min (median 75 min) in IHD- patients (P=0.95). TOFC was ≤ 60 minutes in 48% of IHD+ patients and in 47% of IHD- patients (P=0.77); TOFC was ≤ 120 minutes in 66% and 63%, respectively (P=0.33). Only few factors were significantly related to a shorter TOFC: greater chest pain intensity (P<0.001), diurnal onset of symptoms from 7:00 am to 11:00 pm (P<0.001), syncope/cardiac arrest as initial symptom (P<0.001), anterior location of MI (P=0.004), higher Killip class on admission (P=0.02), and not living alone (P=0.03). With the only exception of chronic treatment with aspirin (P=0.03), none of the medications used before onset of AMI was associated with a shorter TOFC. Similar results were found when time to first call was compared in patients with (n=517) or without any cardiovascular history (IHD or peripheral artery disease or cerebrovascular disease): median time 75 min in each group.

