negative predictive values (PPV, NPV) and area under the ROC curve (AUC).

Results In our cohort of 105 patients, 18 (17%) had an LVO. VAN was found to have a sensitivity of 0.56, specificity of 0.77, PPV of 0.33, and NPV of 0.89 in predicting LVO, with an AUC of 0.663. RACE demonstrated a sensitivity of 0.67, specificity of 0.79, PPV of 0.40, and NPV of 0.92, with an AUC of 0.730. In patients with time since last known well (LKW) of ≤ 1.5 hours (n = 42), VAN and RACE both demonstrated superior performance and high NPV (VAN NPV = 0.93, RACE NPV = 0.96).

Conclusions Both VAN and RACE demonstrated measurable but limited benefit in predicting LVO in the field. In patients with LKW times of ≤1.5 hours, RACE showed a high NPV of 0.96. In this subset of patients, RACE could be used to rule out LVO in the prehospital setting, avoiding delays in care due to unnecessary transport to a thrombectomy-capable facility.


E-059 EPTIFIBATIDE BRIDGING THERAPY FOR STAGED CAROTID ARTERY STENTING AND CARDIAC SURGERY


Background Prophylactic carotid artery stenting (CAS) is an effective strategy to reduce perioperative stroke in patients with severe carotid stenosis who require cardiothoracic surgery (CTS). Staging both procedures (CAS-CTS) during a single hospitalization presents conflicting demands for antiplatelet therapy and the optimal pharmacologic strategy between procedures is not established. Eptifibatide (Integrillin), a parenteral GP IIb/IIIa antiplatelet agent with a half-life of 2.5 hours, is an appealing alternative to oral thienopyridines, enabling rapid reversal prior to sternotomy. The purpose of this study is to present our initial experience with a “bridging” eptifibatide protocol for staged CAS-CTS.

Methods A retrospective review of staged CAS-CTS procedures at a single referral center was performed. All patients had multivessel coronary and/or valvular disease and severe carotid stenosis (>70%) confirmed during preoperative risk assessment. Per the institutional protocol (figure 1), all patients not previously on aspirin were also started on aspirin prior to surgery, followed by eptifibatide during CAS (intraprocedural bolus followed by post-procedural infusion which was continued until the morning of surgery). Pre- and perioperative (30 days) neurologic morbidity and mortality was the primary endpoint.

Results 11 CAS procedures were performed in ten patients using the protocol. The median duration of eptifibatide bridge therapy was 36 hours (range 24-288hrs). There was one minor bleeding complication (1/11, 9.1%) and no major bleeding complications during the bridging and post-operative period. There was one post-operative, non-neurologic death and zero perioperative ischemic strokes.

Conclusions For patients undergoing staged CAS-CTS, Eptifibatide bridging therapy is a viable temporary antiplatelet strategy with a favorable safety profile. This strategy enables a flexible range of time-intervals between procedures.