outcome was major adverse cardiovascular events (MACE). Secondary outcomes included all-cause death and major bleeding. We performed Bayesian network meta-analyses to compare all interventions simultaneously using the Markov-chain Monte Carlo method, conducted under the assumption of transitivity. We generated odds ratios (ORs) with 95% credible intervals (CrI) from the medians and 2.5th and 97.5th percentiles of the posterior distributions using a hierarchical Bayesian framework, using a random-effects model with informative priors for between-study heterogeneity based on pharmacological interventions with semi-objective outcomes (MACE or bleeding) or death. To rank interventions for each outcome, we calculated the mean surface under the cumulative ranking (SUCRA) curve. From 5941 articles, we included 24 RCTs enrolling 89,620 patients. Both clopidogrel- and ticagrelor-based DAPT increased MACE compared with pharmacogenomics-guided P2Y12 inhibitor selection (odds ratio [OR] 1.37, 95% credible interval [CrI] 1.08-1.74 and 1.35, 1.05-1.79, respectively) and empiric P2Y12 inhibitor de-escalation (OR 1.53, 95% CrI 1.00-2.30 and 1.51, 1.00-2.27, respectively). Compared with short-duration DAPT, standard DAPT duration with all P2Y12 inhibitors (clopidogrel, prasugrel, ticagrelor) and pharmacogenomics-guided P2Y12 inhibitor selection increased major bleeding. Ticagrelor-based DAPT increased major bleeding compared with platelet function testing-guided DAPT (OR 1.60, 95% CrI 1.00-2.55). Empiric P2Y12 inhibitor de-escalation ranked best for MACE (SUCRA 0.89), whereas short-duration DAPT ranked best for death (SUCRA 0.89) and major bleeding (SUCRA 0.93).

CONCLUSION: In patients with ACS, empiric P2Y12 inhibitor de-escalation was most efficacious whereas short-duration DAPT was the safest compared to other DAPT strategies.

Figure. Network meta-analysis results for DAPT strategies compared with clopidogrel.

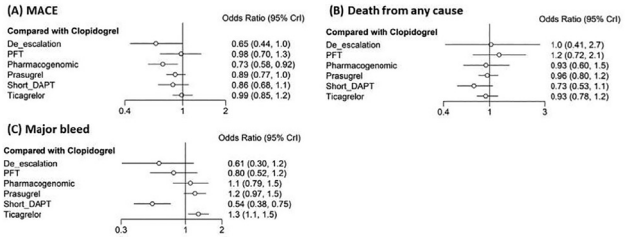

Table. Network meta-analysis results for MACE (left lower half) and major bleeding (right upper half)

Clopidogrel	0.84 (0.68-1.03)	*0.79 (0.65-0.95)*	1.64 (0.86-3.29)	0.91 (0.65-1.27)	1.25 (0.80-1.94)	*1.86 (1.33-2.63)*
1.13 (0.96-1.29)	Prasugrel	0.94 (0.74-1.18)	*1.96 (1.03-3.94)*	1.09 (0.74-1.59)	1.49 (0.95-2.33)	*2.22 (1.53-3.24)*
1.01 (0.85-1.17)	0.90 (0.75-1.08)	Ticagrelor	*2.09 (1.12-4.10)*	1.16 (0.82-1.66)	*1.60 (1.00-2.55)*	*2.37 (1.76-3.23)*
1.53 (1.00-2.30)	1.36 (0.90-2.03)	*1.51 (1.00-2.27)*	De-escalation	0.56 (0.26-1.14)	0.76 (0.34-1.65)	1.13 (0.55-2.27)
1.37 (1.08-1.73)	1.22 (0.93-1.61)	*1.35 (1.05-1.78)*	0.90 (0.56-1.44)	Pharmacogenomics	1.37 (0.79-2.37)	*2.04 (1.31-3.22)*
1.02 (0.74-1.43)	0.91 (0.66-1.29)	1.01 (0.72-1.47)	0.67 (0.41-1.14)	0.75 (0.50-1.12)	Platelet function testing	1.49 (0.87-2.56)
1.17 (0.91-1.48)	1.04 (0.80-1.35)	1.15 (0.93-1.43)	0.76 (0.49-1.21)	0.85 (0.61-1.17)	1.14 (0.75-1.69)	Short DAPT

OR <1 favor the column-defining treatment for MACE and the row-defining treatment for major bleeding.

P028
EARLY SUCCESS AND COST-EFFECTIVENESS OF A SOCIAL MEDIA CAMPAIGN TO REDUCE PRE-HOSPITAL DELAYS IN PATIENTS WITH POSSIBLE ACUTE CORONARY SYNDROME

K Marshall, H Memon, E Czaplinski, R Grierson, L Avery, J Ducas, S Liu

Winnipeg, Manitoba

BACKGROUND: Despite many improvements in percutaneous coronary intervention (PCI) and hospital systems of care, prehospital delay remains a significant barrier to timely reperfusion in acute coronary syndromes (ACS). Prolonged delays to reperfusion results in poor patient outcomes. There is data to support the efficacy of educational interventions to reduce patient-related prehospital delay in the setting of possible ACS, especially in chest pain patients. Traditional media such as television and radio are highly dependent on a ratings system: that is, how many people in an audience can be reached. Given the recent decline of television viewership and radio audiences, these are less reliable forms of message transmission. In addition, cost remains high, further lowering cost-effectiveness when funding a campaign. Hence, we have launched a novel low-cost social media-based education campaign targeting patients with chest pain to reduce pre-hospital delays.

METHODS AND RESULTS: The primary message of our campaign is three-pronged: to have patients recognize the most common signs of a heart attack (chest pain, shortness of breath, diaphoresis), to call 911 to seek medical care quickly, and not to drive themselves to the hospital. Our motto is: "Dial, Don't Drive". In the first 8 weeks of our campaign, we created 17 posts on Facebook and Instagram. We focused on "Team Heart Attack" – introducing the team of healthcare professionals who care for ACS patients; "Patient Voices" – telling patient stories; and "ACS Education" – sharing common and uncommon symptoms of ACS, common medications and the importance of seeking medical attention in a timely fashion (see Figure for examples). We have reached a 62,700 people through Facebook, and a further 19,100 via Instagram. We had 102,748 and 33,059 content displays on Facebook and Instagram, respectively. Currently, we have 206 followers on Facebook and 155 on Instagram. The total cost of this campaign was $903.71 ($737.99 for software and $165.72 for advertisement). As a comparison, tradition media for a billboard in our community is $12,150.00 for 1 month, a weekend newspaper ad is $5880.00 and interior bus post is $8886.08 for 2 months.

CONCLUSION: In the first 8 weeks of the novel social media-based education campaign, there is evidence of our content reaching our target audience and producing engagement with our community. Cost-effectiveness appears to be promising at this early time point. The next phase of the campaign will be targeting patients at high-risk of ACS and those who are at risk of delayed presentation.

Figure 1: Sample posts (thumbnails only) from the "Dial Don't Drive" social media campaign

P029
ESTIMATED PULSE WAVE VELOCITY INDEPENDETLY PREDICTS SURVIVAL-TO-DISCHARGE IN PATIENTS REQUIRING EXTRACORPOREAL MEMBRANE OXYGENATION: A SINGLE-CENTRE RETROSPECTIVE COHORT STUDY

M Malik, D Nagpal

London, Ontario

BACKGROUND: Extracorporeal membrane oxygenation (ECMO) is a life-saving device used to support the respiratory and/or cardiovascular function of acutely ill patients. While this supportive device is widely used in intensive care units around the world, appropriate patient selection is difficult given the high associated morbidity and mortality of those requiring this level of intervention. One possible solution to the heterogeneity of ECMO patients is to determine a variable that reflects a chronic marker of health and has independent strength in predicting overall morbidity and mortality. A suitable candidate for this variable is Arterial Stiffness (AS), a chronic marker of vascular compliance, demonstrated to have strong correlation with cardiovascular disease, peripheral vascular disease, cerebrovascular disease, renal disease, and all-cause mortality. Additionally, AS has been shown to be strongly influenced by systemic inflammation, as seen in ECMO patients. In this study, we aim to understand the benefit of estimated pulse-wave velocity, a metric of AS, as an independent predictor of outcomes and survival-to-discharge in our cohort of ECMO patients.

METHODS AND RESULTS: A retrospective cohort study was performed at the London Health Science Centre (LHSC) in London, Ontario, Canada between 1996-2021, totaling 255 patients requiring ECMO. Estimated pulse wave velocity (ePWV) was calculated using an algorithm generated from the Reference Values for Arterial Stiffness Collaboration. Recorded outcomes included: in-hospital death, ischemic stroke, hemorrhagic stroke, renal failure and need for renal replacement therapy (RRT). For adjusted analysis, survival-to-discharge was used. Multivariate logistic regression and propensity-score matching were utilized to control for confounding. On univariate logistic regression, ePWV was found to have a significant protective effect for renal failure (OR 0.88 [0.78-0.99], p=0.034) and RRT (OR 0.87 [0.77-0.98], p=0.027). Higher ePWV was also found to be significantly predictive of ischemic stroke (OR 1.676 [1.31-2.37], p=0.0002) and in-hospital death (OR 1.20 [1.06-1.38], p=0.006), but insignificant for predicting hemorrhagic stroke (OR 1.07 [0.74-1.55], p=0.710). On multivariate analysis and propensity-score matching, 5 of 6 models demonstrated ePWV as a significant independent predictor of survival-to-discharge. (OR 0.70 [0.57-0.84], p=0.00021, OR 0.72 [0.60-0.86], p=0.0002, OR 0.87 [0.75-1.00], p=0.045, OR 0.85 [0.74-0.97], p=0.013)

CONCLUSION: This study presents ePWV as a promising marker for risk-stratification in ECMO patients. It furthers understanding of the role of arterial health in disease trajectory and strengthens the validity of AS as a marker of interest in medical and surgical management. Further research is needed to validate these findings and develop tangible tools for clinical application.

P030
SAFETY AND FEASIBILITY OF VERY EARLY DISCHARGE IN LOW-RISK PATIENTS WITH STEMI AFTER PRIMARY PCI

S Liang, M McCarthy, S Miner, C Overgaard, W Cantor, K Elliott

Newmarket, Ontario

BACKGROUND: Very early discharge (VED) ($\leq$ 36 hours) for low risk ST segment elevation myocardial infarction (STEMI) patients has been reported in small registries but data on real world clinical outcomes with this approach is limited. We prospectively enrolled low-risk STEMI patients into a VED protocol and compared outcomes with similar patients discharged at 36-72 hours.

METHODS AND RESULTS: Between April 2021- March 2022, 479 patients admitted with STEMI underwent primary PCI (PPCI). Low-risk patients were identified using the University of Ottawa Heart Institute criteria, and after providing informed consent were discharged home 20-36 hours after hospital admission. All patients had telephone follow-up by a nurse practitioner (NP) at 2 days, 7 days and 30 days post discharge. The NP assessed symptoms, and provided education and medication titration. The control group consisted of 82 STEMI patients admitted between 2019-2020 who met the low-risk criteria and were discharged between 36-72 hours as per standard practice. Death, major adverse cardiac events (MACE), re-admissions and ER visits within 30 days were collected for both groups. Additional outcomes which included patients' satisfaction and experience of the VED protocol were measured by a survey after 30 days. Among the 479 STEMI patients undergoing PPCI during the study period, 27% (n=131) were identified as low risk. Of these, 61% (n=80) were enrolled in the VED protocol. 39% of the patients were not enrolled because study investigator's