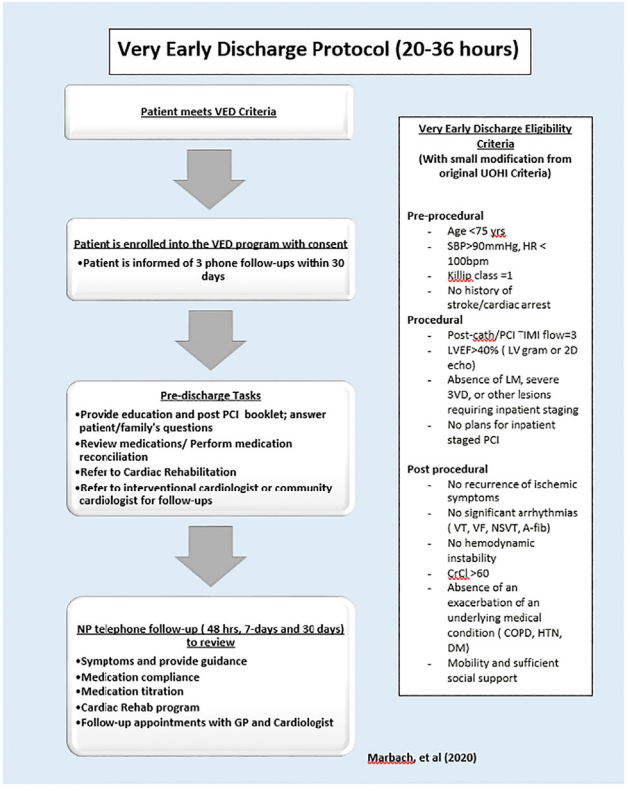
unavailability, patients' repatriation to other hospitals, and physician's / patients' preference. All patients were contacted up to 30 days with no loss to follow-up. The median length of stay (LOS) was 27.2 hours (IQR 9.7 hours) for the VED group and 48.2 hours (IQR 11.8 hours) for the control group ($p < 0.0001$). There were no deaths or MACE in either group. There were no significant differences in the rates of re-admission ($p= 0.36$) and ER visits ($p=0.61$). After 30 days, 94% of the VED patients were pleased with the early discharge, 5% wished they could have stayed in hospital longer, 1% was not available to answer survey questions.

CONCLUSION: Low risk STEMI patients treated with PPCI can be discharged 20-36 hours with the support of a structured virtual 30 day follow-up by an NP. Clinical outcomes appear to be very favorable and similar to patients who are discharged after 36 hours. This strategy appears to be safe and can be a helpful tool to improve clinical efficiency in resource constrained hospital environment.



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THE EFFECT OF BETA BLOCKAGE IN PATIENTS FOLLOWING ACUTE CORONARY SYNDROME - STRATIFIED ACCORDING TO LEFT VENTRICULAR EJECTION FRACTION.

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BACKGROUND: Beta blockers (BB) have been widely accepted as a standard of care in the post myocardial infarction (MI) period. The most recent AHA/ACC and ESC guidelines recommend BB use post-MI. However, the guidelines do admit to limited evidence, particularly in patients with preserved left ventricular ejection fraction (LVEF). There is also a paucity of data for BB use in patients with mild to moderate LV dysfunction. Our study aims to address the benefit of BB's across LVEF subgroups in the post-MI period.

METHODS AND RESULTS: We examined 7955 patients who underwent coronary angiography for a diagnosis of ACS between 2012-2016. Patients were categorized as follows: group 1 (LVEF >50%), group 2 (LVEF 35-50%), and group 3 (LVEF < 35%). LVEF was assessed by trans-thoracic echocardiography, if available, and if not left ventriculography. The primary outcome was all-cause mortality at 1-year. Incidence of the primary outcome was visualized with Kaplan-Meier survival curves. Associations were assessed using Cox proportional hazard modeling. These analyses were performed with and without propensity matching, to account for differences between patients who were or were not prescribed a BB. At index presentation, our cohort had a median age of 62, and 70% of patients were male. Patients who were prescribed beta-blockers were less likely to have a LVEF >50% (64% vs 77%, p< 0.001). Figure 1 shows Kaplan-Meier survival curves stratified by LVEF and BB usage. In patients with LVEF < 35%, BB usage was associated with a significantly reduced all-cause mortality at 1-year (unadjusted hazard ratio [HR] 0.30, p=0.044). Patients with a LVEF 35-50% were less likely to die if prescribed beta-blockers (unadjusted HR 0.42, p=0.001). However, this was not the case in propensity matched analyses (unadjusted HR 0.80, p=0.487). Lastly, there was no significant difference in all-cause mortality in patients with preserved LVEF (unadjusted HR 1.16, p = 0.626).

CONCLUSION: Our study demonstrates that BB use was associated with a significantly reduced all-cause mortality at 1 year in patients with severely reduced LVEF. However, in patients with preserved or mid-range LVEF, BB use was not associated with a significant difference in all-cause mortality using a propensity matched analysis. These results suggest clinicians may not need to be as aggressive in implementing widespread BB usage in patients with preserved or mid-range LVEF post-MI. Further large prospective trials would be of benefit to help further study the mid-range LVEF population.

Figure 1: Kaplan-Meier survival curves according to LVEF subgroup and beta-blocker use.