

Methods and results: From January 2008 to December 2016, 1723 patients (86.4% male, the mean age of 58.4 years) were admitted to our hospital with STEMI and underwent PPCI. TA was performed in 1178 patients (68.1%).

Baseline characteristics were significant different between TA and no TA patients: TA patients were younger, more frequently males and on smoking, had fewer comorbidities (hypertension, diabetes, dyslipidemia, renal insufficiency and ischemic heart disease), the infarct-related artery was less frequently the LAD and had a lower pre-PCI TIMI flow. After propensity score matching no differences among groups were detected.

124 patients died (7.2%) and 269 patients presented MACE (15.6%) during follow up. In the total cohort, there were no differences in the incidence of TIA/stroke (1.55% in TA patients vs 1.44%, P 0.871) this was maintained in the PS-matched cohort (1.56% in TA patients vs 1.07%, P 0.300). No differences were observed in 7 days, 30 days or one-year all-cause mortality and MACE among TA and No-TA groups in both cohorts (total and PS-matched cohort)

Conclusion: In our contemporary STEMI registry the use of TA in PPCI was safe in terms of acute TIA/Stroke, however no outcome benefit was detected at one year.

P056-F | Carcinoid heart disease; the importance of a multidisciplinary heart team

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Background: Neuroendocrine tumors are able to secrete vasoactive substances which may result in carcinoid syndrome. The cardiac manifestations of neuroendocrine tumors are known as carcinoid heart disease and mostly affects right-sided valves, leading to severe regurgitation and/or stenosis and subsequent cardiac decompensation. Treatment consist of medical therapy and/or surgical intervention in selected cases.

Materials and methods: Here we present an illustrative case report of a relatively young patient with carcinoid heart disease. This case highlights the importance of a multidisciplinary heart team in choosing optimal treatment strategy.

Results: A 45-year old female with carcinoid heart disease underwent tricuspid and pulmonic valve replacement with a bioprosthesis. Postoperatively she developed a third degree atrioventricular block for which she received a pacemaker. The ventricular lead was placed in a posterolateral

branch of the coronary sinus. Shortly thereafter she developed severe mitral regurgitation apparently caused by pacing of the papillary muscle. A new ventricular lead was placed anteriorly in the great cardiac vein, resulting in a significant reduction of mitral regurgitation. One year later she was readmitted with clinical signs suspect for recurrent carcinoid heart disease. She underwent successful tricuspid valve replacement with a mechanical valve. Microscopic analysis confirmed recurrent carcinoid heart disease.

Conclusions: In this case report we present a complex disease which requires a multidisciplinary approach. Decisions with regards to valve type (bioprosthesis or mechanical valve) and treatment of complications (atrioventricular block, mitral regurgitation, recurrent heart disease) ought to be made by a dedicated heart team, therefore early referral to a specialized center are of importance. An imaging cardiologist, an electrophysiologist, and a cardiothoracic surgeon were closely involved in the process, which illustrates the crucial role of a heart team in the treatment of patients with this complex disorder.

P057-F | Fracture of the sesamoid bone of the thumb: a case report and summary on literature

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A fractures of the sesamoid bone of metacarpophalangeal joint is rare. Here we present a case of a 26-year old female patient with a hyperextension trauma of the thumb causing an isolated, complete fracture of the ulnar sesamoid bone of the thumb MCP joint. Injury of the volar plate was excluded. In an additional systematic literature search we found 40 cases. In 73% the ulnar sesamoid bone was fractured, and in 24% an isolated fracture of the radial sesamoid bone occurred. The injury most often occurs during sports (50%). Immobilisation was the therapy of choice in 80% of the cases. In most of these cases immobilization was <4 weeks (78%) or even <3 weeks (63%). Full recovery was established in 91% of the cases, of which 50% recovered <8 weeks. Physicians should be aware of this uncommon trauma. We advise a short period of immobilisation, not more than 3 weeks, and early physical treatment if required.