segment elevation acute coronary syndrome' (NSTE-ACS), we the patient based on the available ECGs and troponins. Patients with an elevated high sensitive troponin T (hsTropT) from other conditions were excluded.

Baseline characteristics were obtained from the clinical records. A detailed list of the baseline characteristics can be found in Online Appendix A.

Setting

T is study was performed at an academic CCU (Academic Medical Center (AMC), University of Amsterdam, T e Netherlands). It is a large tertiary center with both percutaneous coronary intervention (PCI) and on-site cardiac surgery facilities. At the time of the registration, the annual coronary artery bypass gra f ing (CABG) (without valve) volume was ~500. T e annual PCI volume was ~2000, of which ~600 primary PCI.

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	ACS study cohort	STEMI	NSTEMI	UA	P value
Patient characteristics					
Cardiovascular medical history					

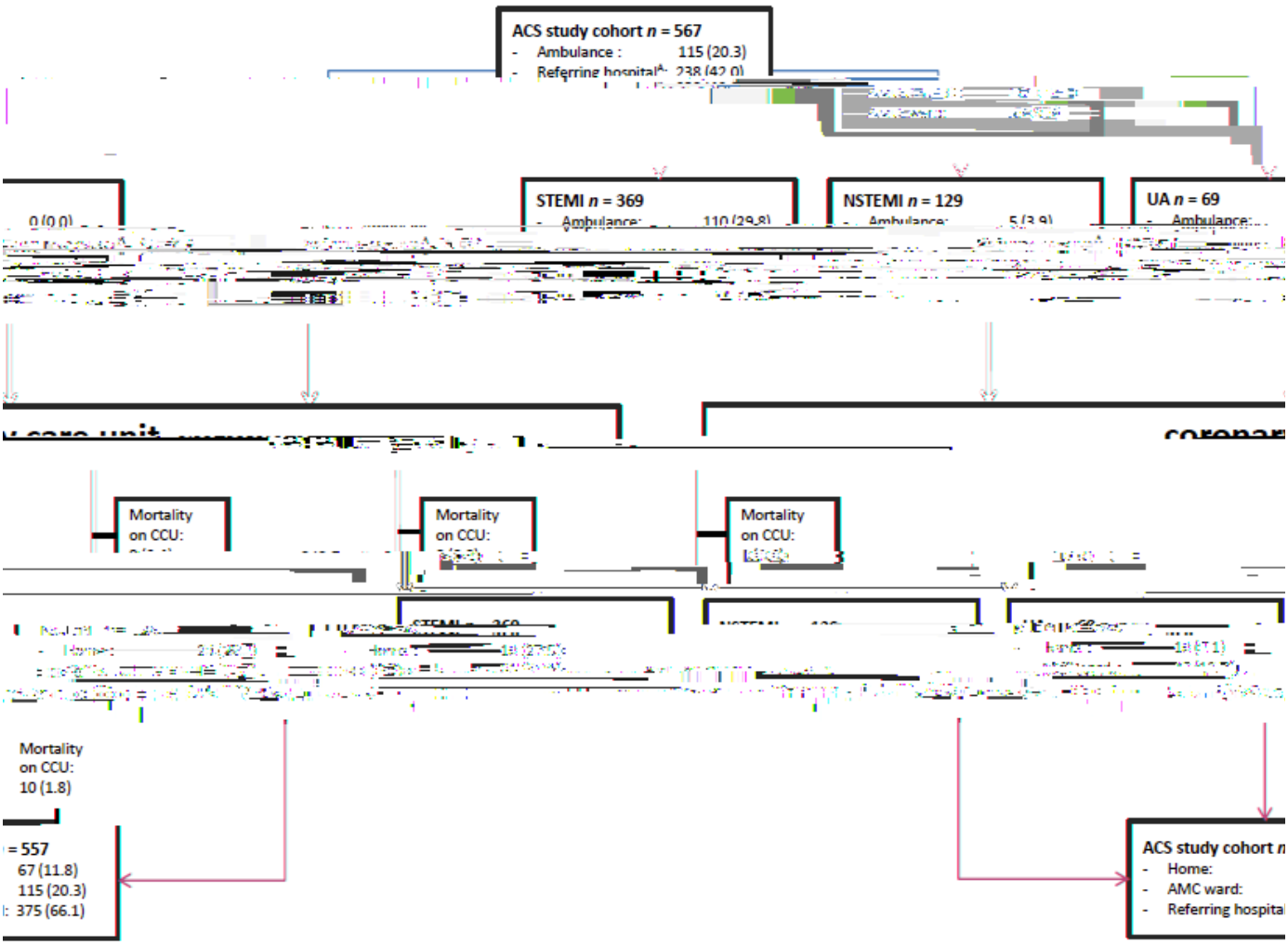

Figure 1: Flowchart: route of admission to and discharge from our coronary care unit. All values are reported as numbers (%); ACS: Acute Coronary Syndrome; CCU: Coronary Care Unit; CPU: Chest Pain Unit; ED: Emergency Department; NSTEMI: Non-ST-segment Elevation Myocardial Infarction; STEMI: ST-segment Elevation Myocardial Infarction; UA: Unstable Angina; A) Transported to our CCU by ambulance with an emergency or transport drive after referral from another hospital, of which a considerable proportion was actually transferred directly from home by ambulance using the pre-hospital ECG triage network, with consultation between the ambulance personnel and the referring cardiologist.

patients (65.6%) were less frequently treated with PCI (50.0% 70.2%, p=0.024) and more frequently with CABG (20.5% 3.6%, p=0.002). High-risk patients tended to have more often a prior CABG (18.2% 7.1%, p=0.057). In UA patients with a GRACE score >140 compared to ≤140 management strategies were similar.

	ACS study cohort	STEMI	NSTEMI	UA	P value
Duration of stay on CCU (hours) – median (IQR)					
Treatment strategy					

Table 2: In-hospital treatment. ACS: Acute Coronary Syndrome; CABG: Coronary Artery Bypass Grafing; CAG: Coronary Angiography; CCU:

Stratification by one-year mortality

ACS patients deceased at one year follow-up (group A) were significantly older (74.2 with standard deviation (SD) 9.7 years vs. 62.8 with SD 12.4 years, $p<0.001$) and more often female (44.7% vs. 29.9%, $p=0.036$) compared to those alive (group B). Chronic kidney disease (CKD) was more common in group A (54.3% vs. 17.3%, $p<0.001$) as was a prior stroke (25.5% vs. 8.3%, $p=0.001$). An invasive strategy (group A 85.1% vs. group B 94.7%, $p=0.009$) and revascularization (group A 72.3% vs. group B 87.2%, $p=0.005$) were significantly correlated with higher one-year survival.

In the complete ACS study cohort, female compared to male patients were significantly older and had more often CKD. Furthermore, women and men had similar percentages of CAG, but women less frequently underwent revascularization.

Discussion

The current unselected ACS population admitted to our academic

20. Hvelplund A, Galatius S, Madsen M, Rasmussen JN, Rasmussen S, et al.