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ABSTRACTS PRESENTED AT



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ARTIGO RETIRADO

110777

MODALITY: BEST ABSTRACTS ORAL - RESEARCHER
 CATEGORY: HEART FAILURE/ CARDIOMYOPATHY/ TRANSPLANT
 D: 14/10/2022 H: 10:40 / 11:40
 L: AUDITÓRIO 14

TITLE: ACUTE HEART FAILURE IN PATIENTS WITH CHAGAS' CARDIOMYOPATHY IN COMPARISON TO OTHER ETIOLOGIES: RESULTS OF THE I BRAZILIAN HEART FAILURE REGISTRY (BREATHE)

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Background: Chagas cardiomyopathy (CC) is a prevalent cause of heart failure in Latin America countries. Studies describing clinical manifestations and outcomes of heart failure associated to CC are scarce. Purpose: Report the results of the I Brazilian Heart Failure Registry (BREATHE) addressing the clinical and laboratorial characteristics, and outcomes of patients with acute heart failures (AHF) due to CC in comparison to other etiologies. Methods: BREATHE was a multicenter nationwide prospective registry, enrolling 3,013 adult patients hospitalized with AHF; median follow-up of 346 days. We proceeded the comparative analysis between 261 (8.7%) patients with CC and 2,752 (91.3%) patients with other etiologies, concerning clinical, demographic, cardiac structure/function on Echocardiogram, death rate or heart transplantation during hospital stay and death rate at 3, 6 and 12 months after discharge. The categorical variables were compared by using Fisher Exact test and the continuous variables were compared by using Mann-Whitney test. A multivariate logistic model was used to estimate the odds ratio of CC in 12-month mortality adjusted for clinically relevant variables. Results: CC patients, in comparison to other etiologies, were younger (60.6±13.9 vs 65.7±15.7 y.o., p<0.001), presented lower systolic blood pressure (108.3 ± 26.1 vs 128.3 ± 30.3 mmHg, p<0.001), lower heart rate (77.3 ± 22.1 vs 88.5 ± 23.2 bpm, p<0.001), higher rate of jugular vein distension (54.8% vs 38.9%, p<0.001) and hepatomegaly (47.9% vs 25.6%, p<0.001), higher rate of "cold and wet" clinical hemodynamic profile (27.2 vs 10.6%, p<0.001); larger diastolic left ventricular (LV) diameters (65 [57 - 72.8] vs 59 [51 - 66] mm, p<0.001), and lower LV ejection fraction (25.4 [19 - 36] vs 37 [27 - 54] %, p<0.001), with higher rates of dobutamine use (23.8% vs 6.8%, p<0.001); presented higher rate of death or heart transplantation during hospital stay (11.1% vs 17.4%, p=0.004), and higher cumulative death rate after discharge at 3-months (16.5% vs 10.8%, p=0.017, at 6-months (25.7% vs 17.5%, p=0.006, and at 12-months (40.8% vs 27.8%, p<0.001). In a multivariate analysis, CC was independently associated with 12-month mortality risk with odds ratio = 2.02 [95% CI: 1.47;2.77]. Conclusions: Patients hospitalized with AHF with CC etiology, in comparison to other etiologies, presented higher-risk profile that was associated with a poorer outcome during hospital stay and after discharge.

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MODALITY: BEST ABSTRACTS ORAL - RESEARCHER
 CATEGORY: ACUTE AND CHRONIC CORONARY DISEASE/ THROMBOLYSIS
 D: 14/10/2022 H: 10:40 / 11:40
 L: AUDITÓRIO 14

TITLE: IN-HOSPITAL PROGRAM TO SYSTEMATIZE CHEST PAIN PROTOCOL (IN-HOPE)

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Background: Chest pain is a major cause of medical evaluation at emergency department (ED) and demands observation in order to exclude the diagnosis of acute myocardial infarction (AMI). Recent algorithms using high-sensitivity cardiac troponin assays at 0 h and 1 h are accepted as a rule-out/rule-in strategy but there is a lack of validation in specific populations. Methods: IN-HOPE was a multicenter prospective study that included patients admitted to the ED due to suspected symptoms of AMI at 16 sites in Brazil. All patients followed the standard approach of 0-3h but, in addition, blood samples were also collected at 0 and 1 hour and sent to a core laboratory to measure high sensitivity troponin T (hs-cTn T) Elecsys (Roche). Troponin < 12 ng/L with a delta < 3 was considered rule out while a value ≥ 52 and/or a delta ≥ 5 was considered rule in for AMI. The main objective of the study was to assess the accuracy of 0-1 h rule-out/rule-in algorithm in comparison to the standard of care (0-3h). All patients were followed for 30 days. In addition to the prospective cohort, a retrospective analysis was performed assessing all patients with hs-cTn T measured during 2021 but not included in the prospective cohort. Results: A total of 5,497 patients were included (583 in the prospective and 4,914 in the retrospective analysis). The prospective cohort had a mean age of 57.3 (± 14.8) and 45.6% of females with a mean HEART score of 4.0 ± 2.2. By the core lab analysis, 71.6% would be eligible for a rule-out approach while 7.3% would fit the rule-in criteria. At 30 days, no death or AMI occurred in the rule-out group while 64.9% of the patients in the rule-in group were considered as AMI. In the retrospective analysis, 1,091 patients had a troponin value < 5 ng/L without cardiovascular deaths in this group. Among all 4,914 patients, the 30-day risk of AMI or cardiovascular death increased according to the level of troponin: 0% in the group < 5 ng/L, 0.6% between 5 and 14 ng/L, 2.2% between 14 and 42 ng/L, 6.3% between 42 and 90 ng/L and 7.7% in the level ≥ 90 ng/L. Conclusions: In this large multicentre Brazilian study, a 0-1h algorithm was effective for classifying as rule in or out almost 80% of the patients. The rule-out protocol had high negative predictive value regardless clinical risk scores. Categories of levels of hs-cTn T also showed good accuracy in discriminating risk of the patients with a very favourable prognosis for the group with values < 5 ng/L.

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MODALITY: BEST ABSTRACTS ORAL - RESEARCHER
 CATEGORY: CARDIOVASCULAR SURGERY
 D: 14/10/2022 H: 10:40 / 11:40
 L: AUDITÓRIO 14

TITLE: PERIOPERATIVE CARDIOVASCULAR EVENTS AND MORTALITY AFTER CARDIAC SURGERY ACROSS THE SPECTRUM OF CHRONIC KIDNEY DISEASE

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Background. Previous studies addressing the association of chronic kidney disease (CKD) and prognosis after open-heart surgery had limited sample sizes and retrospective designs. Methods. We investigated the association of preoperative renal function and in-hospital mortality, and major cardiac and cerebrovascular events (MACCE) in patients enrolled in the prospective multicentric VISION Cardiac Surgery Study. Patients were divided in 5 CKD stages according to preoperative estimated glomerular filtration rate (eGFR in mL/min/1.73m²): Stage I (>90, n=1914), Stage II (60 to 89, n=8122), Stage III (30 to 59, n=3406), Stage IV (< 30, n=352) and Stage V (dialysis, n=227). Results. 15,837 were included in the current analysis (71% male, 66% hypertensive and 20% >75 y.o.). Mortality and MACCE during the first 30 days occurred in 480 (3%) and 1727 (11%) patients, respectively. Logistic regression models adjusted for EuroSCORE demonstrated increased 30-day mortality in CKD Stage III (odd ratio [OR], 1.82; 95% confidence interval [CI], 1.36-2.41), CKD Stage IV (OR, 2.62; 95% CI, 1.66-4.15) and in patients in dialysis (OR, 3.56; 95% CI, 2.17-5.85) in analysis across the whole spectrum of renal function (Figure), mortality was increased particularly when eGFR was < 45 mL/min/1.73m², while MACCE risk was observed in less severe stages of CKD. Conclusion. In this contemporary cohort, CKD was significantly associated with morbidity and mortality after open-heart surgery.

