was first diagnosed at 17+19 years, that was earlier than in group 3 where AR was first diagnosed at 21+22 years. The type of o-VSD (subarterial vs. outlet muscular) in groups 1-4 was; 15 vs. 13, 24 vs. 15, and 16 vs. 9 (p<0.01). The left coronary cusp prolapse (RCCP) was firstly detected at significantly younger age than in the IVGG era (7.7±4.3 vs 10.2±7.9; p=0.015), but 33% of pts pre-IVGG and 22% in the IVGG group were diagnosed late with < 5 criteria. The number of pts with <5 criteria was not significantly different between the groups (26% in IVGG group versus 24% in pre-IVGG; p=NS). Incidence of CAA was similar in pts with <5 criteria (13.7%; 95% CI, 8.3% to 21%) and pts with ≥5 criteria (10.2%; 95% CI, 5.8% to 17.5%). Of the 30 pts in the IVGG era diagnosed late, 1.4/30 (4.7%) had CAA (compared with 0.0% in the pre-IVGG group; p<0.05). None of the 30 pts in the IVGG era with evidence of CAA died compared with 13% (12/90) of pts pre-IVGG (p=NS). Conclusions: The use of cAA criteria in this patients with <5 criteria led to the echo diagnosis of CAA. These data emphasize the need for a high index of suspicion of KD in children with < 5 criteria and for continued education about the importance of prompt Dx. The results suggest that strict adherence to current criteria prevents the timely diagnosis of KD in a significant number of cases.

Aortic Regurgitation in an Outlet Ventricular Septal Defect Complicated by Right Coronary Cusp Prolapse: Predictors of Prognosis

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Background: Early surgery to prevent progressive aortic regurgitation (AR) is commonly recommended for patients with aortic valve disease. However, the factors that lead to over-diagnosis of AR remain unclear. The aim of this study was to evaluate the factors that lead to over-diagnosis of AR.

Methods: The study population consisted of 120 consecutive patients with aortic valve disease who underwent transcatheter aortic valve replacement (TAVR) at our institution from January 1, 2010, to December 31, 2019. The patients were divided into two groups: Group A (n=70) with AR and Group B (n=50) without AR. The baseline characteristics of the two groups were compared. The predictors of AR were determined by univariate and multivariate analyses.

Results: The rate of AR in Group A was significantly higher than that in Group B (48.5% vs 12.0%, p<0.05). The predictors of AR were determined by univariate and multivariate analyses. The predictors of AR were diastolic dysfunction (odds ratio [OR] 3.5, 95% confidence interval [CI] 1.7-7.3, p<0.001), left ventricular ejection fraction (LVEF) (OR 0.9, 95% CI 0.8-1.0, p=0.02), and left atrial appendage area (OR 0.9, 95% CI 0.8-1.0, p=0.02).

Conclusion: Early surgery to prevent progressive aortic regurgitation (AR) is commonly recommended for patients with aortic valve disease. However, the factors that lead to over-diagnosis of AR remain unclear. The aim of this study was to evaluate the factors that lead to over-diagnosis of AR. The predictors of AR were determined by univariate and multivariate analyses. The predictors of AR were diastolic dysfunction (odds ratio [OR] 3.5, 95% confidence interval [CI] 1.7-7.3, p<0.001), left ventricular ejection fraction (LVEF) (OR 0.9, 95% CI 0.8-1.0, p=0.02), and left atrial appendage area (OR 0.9, 95% CI 0.8-1.0, p=0.02).