Age≥60 years (p<0.001), male (p<0.001), diabetes (68%) and hypertension (59%) were associated with SA. Most patients with SA were sleepy (Epworth score >10).

Risk factors for central SA were age>60 years, male, sever heart failure: III-IV NYHA; diastolic dysfunction whereas risk factors for obstructive SA were age ≥60 years (p≤0.01), male (p≤0.001), BMI ≥23 Kg/m² (p≤0.001), Epworth score >10 (p≤0.02) and diastolic dysfunction (p≤0.05).

Multivariate analysis showed only High body mass index is associated with obstructive SA and NYHA III-IV and low left ejection fraction were in central SA.

Conclusions: In our HF population, SA was prevalent, frequently asymptomatic and without characteristic risk factors. Unlike previously reported, central SA was the predominant type. These results suggest that SA is under diagnosed in HF and there is a possible correlation between them, independent of confounding factors. Recent advances in HF therapy might influence prevalence and type of SA in this population.

061

Short- and long-term effects of nocturnal oxygen therapy on sleep apnea in chronic heart failure
Philippe Border, Sébastien Orazio
Hôpital cardiological du Haut-Lévêque, Pessac, France

Background: To study short- and long-term effects of nocturnal oxygen therapy (NOT) on sleep apnea (SA) in chronic heart failure (CHF).

Methods: In 51 consecutive stable CHF patients, NYHA II/III, left ventricular ejection fraction (LVEF) ≤45%, baseline nocturnal ventilation polygraphy identified 33 SA patients (apnea-hypopnea index (AHI) ≥15 events/h) who were randomized to receive NOT 3 L/min (n=19) or no NOT (n=14). NOT was applied for 6 months with a home concentrator, the first night with polygraphy. Sixteen patients with NOT and 14 without NOT had polygraphy after 6 months.

Results: In patients without NOT, there was no significant difference between baseline and the sixth month. In NOT patients, a marked AHI reduction was observed between baseline versus the first night and the sixth month, respectively, 36.8±22.6 versus 20.8±3.0 and 18.3±2.4 events/h (p<0.0001) and related to a central AHI decrease, respectively, 23.3±2.8 versus 8.3±1.6 and 6.1±1.4 events/h (p<0.0001). The oxygen desaturation index (ODI) evolved similarly: 33.0±5.2 versus 7.5±0.5 and 9.3±2.6 events/h (p<0.0001). NOT had no effects on obstructive and mixed AHI. In NOT patients versus those without, respectively, AHI decreased by 49.0±6.0% versus increased by 2.0±14.0% (p<0.0001), ODI decreased by 59.0±9.4% versus increased by 6.4±14.7% (p<0.004), SaO2<90% time decreased by 61.4±9.9% versus increased by 60.0±88.8% (p=0.1) and LVEF increased by 14.5±10.2% versus 5.6±16.1% (p=0.6).

Conclusions: In stable CHF patients, NOT significantly reduced central AHI and ODI, with acute effects being sustained over time and impacting neither obstructive and mixed AHI nor daytime LVEF.

062

Treatment of heart failure in the real life: clinical inertia early after discharge worsens outcome
Emmanuelle Berthelot-Garcia (1), Richard Isnard (2), Thibaud Damy (3), Erwan Donal (4), Michel Galinier (5), Jean-Noel Trochu (6), Jean Jacques Dujardin (7), Genevieve Mulak (8), Damien Logeart (1)

Background: After acute decompensated heart failure (ADHF), most patients are often early discharged before treatment optimization. Following months are important to optimize the treatment. We analyzed treatments at discharge and at 3 months after discharge and the impact on outcome in patients with heart failure and reduced left ventricular ejection fraction (HF-REF).

Methods: French Society of Cardiology conducted a one-day national survey in a randomized sample of 170 hospitals. All hospitalized patients with a confirmed diagnosis of ADHF were included. Data were recorded during both hospitalizations and one-year follow up.

Results: Treatment informations at discharge as well as at 3 months were obtained in 519 patients (age 72±14y, 34% females). At discharge, loop diuretics were prescribed in 89% cases with daily dose of 87±146 mg, ACE-I or ARB in 80% cases with daily dose reaching 36±31% of target dose, beta blocker (BB) in 70% with daily dose of 27±51% of target dose, aldosterone antagonists (AA) in 23% and digoxin in 9%. At 3 months, there was only few changes in mean rates of prescriptions as compared to discharge (Table).

Clinical characteristics significantly associated with the lack of prescription at 3 months were creatininemia >15 mg/l for ACE-I/ARB, BB and AA, LVEF >30% for BB and AA, and also COPD for BB.

All-cause-mortality at 12 months was 19% with marked differences according to prescription of or not of ACE-I/ARB at 3 months (15 vs 29%, p=0.002) as well as BB (15 vs 27%, p=0.008). After adjustment on clinical characteristics (age, blood pressure, creatininemia, LVEF, natriuretic peptides, COPD, diabetes), lack of treatment at 3 months was an independant predictor of mortality especially ACE-I or ARB (HR 2.50 [95%CI 1.33-4.73], p=0.005).

Conclusion: Individual treatments are poorly optimized after discharge. Such inertia leads to poor outcome, that suggests a room to improve HF management in the practice, especially in the 3 months after discharge.

Table : Treatment changes

<table>
<thead>
<tr>
<th>Treatment’s change after discharges</th>
<th>Stared</th>
<th>Increased</th>
<th>Decreased</th>
<th>Median dose at discharge 3 months</th>
<th>Median dose at discharge 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loop diuretics</td>
<td>7%</td>
<td>6%</td>
<td>25%</td>
<td>40 mg/day [40-100]</td>
<td>40 mg/day [20-80]</td>
</tr>
<tr>
<td>ACE-I or ARB</td>
<td>6%</td>
<td>10%</td>
<td>21%</td>
<td>25 % of target dose [25-50]</td>
<td>25 % of target dose [6-50]</td>
</tr>
<tr>
<td>Betablockers</td>
<td>8%</td>
<td>9%</td>
<td>20%</td>
<td>25 % of target dose [12.5-50]</td>
<td>12.5 % of target dose [0-50]</td>
</tr>
<tr>
<td>Aldosterone inhibitors</td>
<td>20%</td>
<td>6%</td>
<td></td>
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</tr>
</tbody>
</table>

063

Recipients and donors profile evolution in cardiac transplantation. Single centre ten years experience.
Cosimo D’Alessandro (1), Moijan Laali (2), Elezodoro Barreda (2), Varnous Shaida (2), Pascal Leprince (2), Alain Pavie (3)
(1) Hôpital La Pitié-Salpêtrière, Paris, France – (2) Hôpital La Pitié-Salpêtrière, Service de chirurgie thoracique et cardiovasculaire, Paris, France – (3) Hôpital La Pitié-Salpêtrière, Chirurgie thoracique et cardiovasculaire, Paris, France

Objectives: We evaluated our 10-years experience in cardiac transplantation, taking into account the evolution of recipients and donors profiles.

Methods: Between January 2000 and December 2010, 664 patients underwent isolated cardiac transplantation. Patients transplanted between 2000 and 2004 (Group I, n=243) have been compared to patients transplanted between 2005 and 2010 (Group II, n=421).

Results: The following characteristics were significantly different between the two groups: among the recipients, age, 45 years (group I) vs. 48 years (group II) p=0.01; high-emergency waiting list, 1% (group I) vs. 40% (group II), p=0.01; days on waiting list, 162 (group I) vs. 119 (group II), p=0.01; diabetes, 10% (group I) vs. 16% (group II), p=0.02; preoperative mechanical circulatory support with VAD, 20% (group I) vs. 8% (group II), p=0.01; preoperative ECMO, 0% (group I) vs. 16% (group II), p=0.01 ; preoperative...