PHS3
CACHEXIA & DEBILITY IN HOSPITALIZED CHILDREN WITH COMPLEX CHRONIC CONDITIONS
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OBJECTIVES: To characterize the frequency, cost, and hospital-reported outcomes of cachexia and debility in children with complex chronic conditions (CCC). METHODS: We analyzed data from the 2003-2012 data releases of the Kids' Inpatient Database (Healthcare Cost & Utilization Project, Agency for Healthcare Research & Quality), utilizing International Classification of Diseases, 9th Revision (ICD-9) diagnosis codes to identify cases. We compared patient and hospitalization characteristics for CCC with and without cachexia (ICD-9 799.4) and debility (ICD-9 799.3). We examined factors which predict odds of inpatient mortality in CCC using a logistic regression model and factors which impact length of stay and cost. RESULTS: We identified 1,369,562 hospitalizations with CCC and 89,205 with cachexia. Median charges and costs were significantly higher for children with cachexia (p < 0.001). The frequency of cachexia diagnoses increased significantly (p<0.001) from 2003 to 2012, during the sample period, which increased from 277 discharges in 2003 to 473 discharges in 2012, 421 discharges which included debility which increased from 39 discharges in 2003 to 217 discharges in 2012. During the sample period, 5.73% and 2.44% of CCC with cachexia and debility, respectively, died during their hospital stay. Cachexia was associated with a 59% increase in odds of inpatient mortality while debility was associated with a 41% decrease in odds of mortality. Both cachexia and debility increased hospital length of stay (55% and 31% longer stays, respectively). The median cost of hospitalization was $15,441.59 and $23,796.16 for children with cachexia and debility, respectively. CONCLUSIONS: The frequency of cachexia diagnoses in CCC is less than that for adults; however, the frequencies of cachexia diagnoses are increasing over time. Estimates of the incidence of hospitalization with cachexia and debility have not been fully reported in the literature, but our study demonstrates that the frequency of these discharges is also increasing.

PHS4
PATIENT AND HOSPITAL-LEVEL FACTORS ASSOCIATED WITH INPATIENT MORTALITY OF STROKE PATIENTS
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OBJECTIVES: To identify patient-level and hospital-level factors associated with inpatient mortality in a cohort of ischemic stroke patients. METHODS: The 2012 U.S. Nationwide Inpatient Sample was used to identify patients with a primary diagnosis of ischemic stroke (ICD-9: 433,434,436) in the South Region. Backward selection technique with logistic regression was performed to identify unique patient-level and hospital-level factors associated with inpatient mortality. The multivariable analysis included 295,105 patients with more than 30 stroke cases in the southern region of the U.S. RESULTS: There were 19,071 hospitalizations for stroke in 320 hospitals in the South Region. The patient-level variables associated with an increased risk of inpatient mortality were age≥65, female gender, being white, expected primary payer Medicaid, private or other, score for risk of mortality, number of procedures, and having comorbidity of paralysis. On the other hand, number of chronic conditions, having major operating room procedure, AIDS, anemia, chronic pulmonary disease were found to be associated with lower risk of mortality. Additionally, interaction terms involving age, number of procedures, race, risk of mortality score and expected payer were found to be significant predictors. As for hospital-level factors, risk factor, urban-teaching [OR=2.33, (p=0.016)], hospital located in counties with higher median household income (RR range 0.82-0.86, p=0.009-0.065), higher density of primary care providers (RR 0.84-0.86, p=0.022-0.041), and more rural health clinics (RR=0.90, p=0.084) were associated with lower odds of mortality. Hospitals with lower RM score (RR=1.43, p=0.004) and those using different structured telephone support (STS) programmes delivered via human-to-human contact (HTHC) or human-to-machine (voice-activated) interface (HMT). RESULTS: Eighteen RCTs were included in the systematic review. Compared with usual care, structured telephone support (STS) programmes delivered via human-to-human contact (HTHC) or human-to-machine (voice-activated) interface (HMT) was associated with a lower risk of mortality for STS HH (Relative Risk, RR: 0.57, 95% CI: 0.36-0.91, p=0.029), but not for HMT. CONCLUSIONS: Remote monitoring programmes (RM) have the potential to deliver specialised care and management to patients with stable heart failure (HF). This review sought to determine whether RM improves outcomes for adults with HF who were stable in the context of coordinated models of care.

PHS7
REMOTE MONITORING STRATEGIES FOR PATIENTS WITH STABLE HEART FAILURE: A SYSTEMATIC REVIEW AND NETWORK META-ANALYSIS
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OBJECTIVES: Remote monitoring strategies (RM) have the potential to deliver specialised care and management to patients with stable heart failure (HF). This review sought to determine whether RM improves outcomes for adults with HF (defined as having no acute event or deterioration in the past 28 days) who are managed in the community (ambulatory or outpatient care setting). METHODS: Fourteen electronic databases covering the biomedical, scientific and grey literature were searched up to November 2013, and additional data was hand-searched as indicated. Two reviewers independently extracted all relevant data. All randomised controlled trials (RCTs) were included. RM interventions included home telemonitoring (TM) with or without support for 12 or 24 hours, and 24/7 home and hospital phone support, monitoring during office hours and 24/7 showed beneficial trends, particularly in reducing all-cause mortality for patients with stable HF. However, due to the complex nature of RM interventions (including both patient heterogeneity within each category), further research should seek to examine the ‘active ingredients’ of RM strategies including suitability of different systems and qualitative research (patient, partners or carers’ experiences) to understand the processes by which RM works.

PHS8
PERFORMANCE OF TWO WORLD HEALTH ORGANIZATION DENGUE CLASSIFICATIONS IN A PEDIATRIC COHORT FROM COLOMBIA
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OBJECTIVES: To characterize the association between childhood dengue severity and the two WHO classifications of dengue. METHODS: This study aimed to examine whether phototherapy (ultraviolet light) B can lower the risk of fractures in vitiligo patients over middle age. METHODS: This retrospective cohort study was carried out in a pediatric university hospital in Cartagena, Colombia. Consecutive patients admitted to the emergency department with a diagnosis of late-onset vitiligo over middle age (mean age 57). Among these patients, 476 (73.3%) received phototherapy equal or more than 12 times yearly, 712 (18.4%) received phototherapy between 1 and 12 times yearly, and 2,404 (62.2%) received no phototherapy. The frequent phototherapy cohort had an increased risk of fracture compared with the phototherapy unreceived cohort (aHR=0.98, 95%CI=0.86-1.05, p=0.719). The stratified analyses showed that the patients aged 40-64 years in the frequent phototherapy cohort had a lower risk of fracture than those in the phototherapy unreceived cohort (aHR=0.89, 95% CI=0.61-1.04, p=0.750). The stratified analyses suggested that the patients aged 40-64 years in the frequent phototherapy cohort had a lower risk of fracture than those in the phototherapy unreceived cohort (aHR=0.89, 95% CI=0.61-1.04, p=0.750). The stratified analyses suggested that a frequent use of phototherapy might reduce the fracture risks among vitiligo patients at middle-age.

PHS5
RISK OF FRACTURES IN VITILIGO PATIENTS TREATED WITH PHOTOTHERAPY
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OBJECTIVES: This study aimed to examine whether phototherapy (ultraviolet light) B can lower the risk of fractures in vitiligo patients over middle age.