

[399] Impact of a Hospitalization for Acute Decompensated Heart Failure on the Treatment: The Argentinean HOSPICAL Registry

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Acute decompensated heart failure (ADHF) is a worldwide major public health problem. Despite the large number of patients hospitalized there has been little effort to improve the quality of care for patients hospitalized with ADHF in Argentina.

Objectives: Evaluate the pharmacologic management before, during and after hospitalization as well as pre discharge strategies used for ADHF.

Material and methods: Between Sep/04 and Feb/05, 301 patients admitted for ADHF were prospectively recruited in 23 Argentinean centers, corresponding to HOSPICAL Registry (mean age, 67.13 years, 60% males, 64% with an ejection fraction <40%).

Results: The intravenous treatment included: diuretics 93% (administered as continuous infusion in 17%); inotropics in 19% (low-dose dopamine 12%, dobutamine 9% and levosimendan 1%); and vasodilators in 139 (46%) patients (nitropruside 7% and nitroglycerin 39%). The in-hospital management of ACE-I, betablockers and spironolactone is showed in the table 1.

The prescription of drugs before hospitalization vs predischage was as following: ACE-I/ARB in 71 vs 78% (p=0.013), betablockers in 48 vs 65% (p<0.001), spironolactone in 29 vs 51% (p<0.001) and diuretics in 60 vs 78% (p<0.001). The most frequent recommendations before discharge were: low-sodium diet (80%), first visit scheduled in the next 10 days (79%), scheduled chemistry control (56%), daily weight (54%), water restriction (47%), elastic diuretics regimen (28%) and physical activity (24%).

Conclusion: The medical treatment of ADHF included more vasodilators than inotropics. The strategy in the use of recommended drugs was favourable (low reduction and high start). However, since the intervention pre discharge was insufficient there are substantial opportunities to improve the quality of care for ADHF patients in the Argentinean hospitals

Table 1

	Increased	Kept	Decreased	Stopped	Started
ACE-I	18.3%	36.4%	4.7%	6.3%	16%
Beta Blockers	6%	23%	9%	7%	26%
Spironolactone	3.7%	21%	1%	3.3%	32%

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[286] Contemporary Management of Acute Decompensated Heart Failure in Argentina: Do We Need a High Complexity To Obtain a Better Outcome? Insights from Hospital Registry

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Novel strategies have been associated with 4% in-hospital mortality among American patients admitted for acute decompensated heart failure (ADHF), but their availability is limited in Latin-America. We sought to evaluate the current clinical profile, management and in-hospital outcome of Argentinean patients with ADHF.

Methods: Multicenter and prospective registry of patients with ADHF based on signs/symptoms of volume overload and/or low output, evidence of cardiac disease, and requiring IV treatment with diuretics, vasodilators and/or inotropics.

Results: Between Sep-04/Feb-05, 301 patients from 23 centers were included. Mean age was 67±13 and 60% males. There was a history of hypertension in 82%, diabetes 25% and atrial fibrillation 22%. Previous diagnosis of CHF was made in 69%, 38% were on NYHA functional class III-IV and 54% had been previously admitted for ADHF. Sudden decompensation occurred in 22%; in 76% a cause was identified. The etiology was ischemic 37%, hypertensive 21%, valvular 16% and Chagas disease 3%. Emergency room was visited in 54%, and 61% were first admitted to ICU. The initial evaluation included ECG, chest film and chemistry in 99%. Echocardiogram was obtained in 81%, (ejection fraction <40 in 64%). Non-pharmacological intervention included oxygen supplementation (82%), CPAP (8%), hemodynamic monitoring (3%), mechanical ventilation (4%), intraaortic balloon pumping (0.6%) and dialysis (0.3%). Angiography was done in 56 patients, 6-minute walking test in 21, Chagas serology in 24 (positive in 5), cardiac troponin measures in 25 (≥ 0.02 ng/mL in 15), and natriuretic peptide in 8. Wet and cold profile were identified in 97% and 23%. Length of stay was 5.6±4 days. Mortality was 5% and independent predictors were systolic blood pressure <100 mmHg (OR=9.6;IC95%:2.7-35;p=0.001), leucocytes >9000 (OR=4.3;IC95%:1.1-17; p=0.037) respiratory rate >25 (OR=4.3;IC95%:1.2-16;p=0.025). IV treatment included diuretics (93%), inotropics (19%) and vasodilators (46%). At discharge, ACE-I/ARB were used in 78%, betablockers 61% and spironolactone 51%.

Conclusion: This population was mostly elderly patients with decompensated CHF. The management was done using low complexity measures, though two thirds presented critical condition. This widely available strategy was associated with short hospital stay and low mortality.

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[315] Influence of Clinical-Hemodynamic Profile at Admission on the Use of Inotropics in Acute Decompensated Heart Failure. Subanalysis of the "Hospical" Argentinean Registry

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Aims: To evaluate the therapeutic approach, use of inotropics (INO) and in-hospital course according with clinical-hemodynamics profiles in patients admitted for ADHF.

Methods: Between Sep-04/Feb-05, 301 patients from 23 centers with clinical diagnosis of ADHF were prospectively included in a multicenter registry. The "wet" profile at admission was identified in 293 (97.3%) 68 had a "cold" state. The subjects were classified in groups: A (Normal) = 2 (0.7%); B (Wet and Warm) = 231 (76.7%); C (Cold) = 6 (2%) and L (Wet and Cold) = 62 (20.6%).

Results: The use of drugs is detailed in Table 1.

Profile	A	B	C	L	p
IV INO	0%	13%	67%	36%	< 0.001
IV Vasodilators	0%	52%	17%	29%	0.003
IV diuretics	50%	94%	67%	92%	0.008
Spirolactone	50%	50%	40%	59%	NS
Beta Blockers	0%	67%	60%	60%	NS
ACE/ I-ARB	0%	81%	80%	68%	0.008

During hospitalization, the incidence in the groups A, B, C y L of refractory HF was 0, 3, 17 and 15% (p=0.001), cardiogenic shock developed in 0, 3, 33 and 5% (p=0.001), and mortality was 0, 4, 17 and 21%, respectively (p<0.001).

INO was used in 56 (19%) patients (dobutamine 9%, dopamine 17%, and levosimendan 1%). Variables independently associated with need of INO were male (OR=2,9;95%CI:1,13-7,5); ejection fraction <40% (OR=2,6;95%CI:1,03-6,4) and "cold" profile (OR=2,9;95%CI:1,3-6,9). INO's use was related to more frequent discontinuation of ACE-I (13 vs 5%,p=0.035), lower starting of beta-blockers (13 vs 30%,p=0.01) and higher increment of spironolactone (11 vs 2%,p=0.002) during hospitalization. In-hospital mortality in subjects with and without INO was 19.6 vs 1,6 (OR=14,8 IC95%:4,5-48,3), and the administration of inotropics remain as independent marker of mortality after adjustment for baseline differences between groups (OR=27,5;95%CI:1,8-85,4).

Conclusions: Clinical-hemodynamic profiles represent a useful tool to identify high-risk patients with ADHF who need more complex therapeutic intervention, including inotropics treatment. These drugs were associated with poor short-term prognosis.

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