and were more symptomatic (NYHA II 55% vs. 31%; p<0.001). Patients with significant TR had larger right ventricles (36.9±7.9mm vs. 32.7±5.0mm, p<0.001), more dilated left and right atria (66.7±13.0mm vs. 57.9±6.3mm and 65.0±13.1mm vs. 55.3±7.5mm; both p<0.001) and presented with worse left ventricular function (LVEF ≤50%; 19% vs. 11%; p=0.020).

In total, 132 (21.9%) patients died during follow up (36.1% with significant TR vs. 18.3% without; p<0.001). 76 (12.6%) patients died of cardiovascular causes (26.2% vs. 9.2%, p<0.001). By Kaplan-Meier analysis, overall survival was significantly worse in patients with significant TR (1-,3- and 5-year survival 91.8%, 81.2% and 63.9% vs. 96.0%, 89.0% and 81.7%, log rank p<0.001).

By multivariable Cox regression analysis, age (p<0.001), left atrial enlargement (p<0.001), coronary artery disease (p=0.001) and significant TR (p=0.008) were found to independently predict cardiovascular mortality.

Conclusion: Significant TR late after left-sided valve surgery is frequent and independently predicts mortality.

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**Clinical and echocardiographic predictors of mortality in patients with severe tricuspid valve regurgitation**

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Objective: To determine the predictors of mortality in patients with severe Tricuspid Regurgitation (TR).

Methods: Consecutive patients with severe TR examined at a tertiary care medical center during 36 months were identified [341 patients (239 hospitalized); age 73±14 yrs, 36% male]. The relationships between demographics, echocardiographic parameters, clinical characteristics and mortality were examined.

Results: During a median follow-up period of 21 months (interquartile range 4-34), 178 patients (52%) died. Survival was significantly different between hospitalized and non-hospitalized patients at 1 yr (57% versus 86%, respectively) and 3 yrs of follow-up (34% versus 73%) (p<0.001; graph). By multivariate Cox regression analysis – Right Ventricular (RV) dysfunction (moderate or severe, present in 19% of patients) (Hazard Ratio [HR] 1.9, 95% Confidence Interval [CI] 1.2-3.0) and Pulmonary Artery Pressure (PAP) > 55 mmHg (median PAP of study population; HR 1.1, CI 1.1-2.5) were independent predictors of mortality, adjusting for age, gender, and hospitalization status. Among hospitalized patients (clinical data were available for analysis) – Charlson comorbidity index ≥3 (present in 55% of patients) was an additional independent predictor of mortality (HR 1.6, CI 1.1-2.5), whereas severe heart failure (NYHA class III-IV) was not. The mortality in a minority of hospitalized patients (n=40) without the above risk factors (RV dysfunction, pulmonary hypertension, or significant comorbidity) was markedly lower than in patients with at least on risk factor (33% versus 69%, respectively, p<0.001).

Conclusion: Lead-induced significant TR is associated with long-term poor prognosis.

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**Impact of antecedent hypertension on the long-term mortality of patients with acute coronary syndrome**

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Hypertension is a known risk factor for cardiovascular outcomes such as acute coronary syndrome (ACS). Influence of antecedent hypertension on the long-term survival of ACS patients according to the type of ACS is not well characterized.

Methods: We included 20,504 patients with ACS in the Eastern Danish Heart...