nal disease (9% vs 4%; p=0.0003). Proportion of health care-associated IE was higher in the bioprostheses group (26% vs 17%; p<0.001). Intracardiac abscesses were more frequent in the bioprostheses group (30% vs 23%; p=0.044). Both in-hospital and 1-year death rates were higher in the bioprostheses group, 20.5% vs 14.0% (p=0.0009) and 25.3% vs 16.6% (p<0.001), respectively. Only 3 variables were independently associated with the type of prostheses implant: (i) atrial fibrillation (odds ratio: 0.64 for every 10 years; 0.56 - 0.73) and (ii) presence of a previous cerebral aneurysm (0.34; 0.18 - 0.65; p=0.002) as the main predictors of ICH. Among the patients with CHF, 5 (15%) died because of this complication; 19 (56%) were treated medically, 7 (21%) had a neurosurgical procedure and 3 (9%) had an interventional endovascular treatment. Of the 27 (79%) patients with an indication of valvular surgery, 3 (11%) died. 6 (22%) were contraindicated because of their neurological status, 2 (7%) were contraindicated for another cause and 16 (59%) were contraindicated for another cause and 16 (59%) had interventional endovascular treatment. Of the 27 (79%) patients with an indication of valvular surgery, 3 (11%) died. 6 (22%) were contraindicated because of their neurological status, 2 (7%) were contraindicated for another cause and 16 (59%) had interventional endovascular treatment. Of the 27 (79%) patients with an indication of valvular surgery, 3 (11%) died. 6 (22%) were contraindicated because of their neurological status, 2 (7%) were contraindicated for another cause and 16 (59%) had interventional endovascular treatment. Of the 27 (79%) patients with an indication of valvular surgery, 3 (11%) died. 6 (22%) were contraindicated because of their neurological status, 2 (7%) were contraindicated for another cause and 16 (59%) had interventional endovascular treatment. Of the 27 (79%) patients with an indication of valvular surgery, 3 (11%) died. 6 (22%) were contraindicated because of their neurological status, 2 (7%) were contraindicated for another cause and 16 (59%) had interventional endovascular treatment. Of the 27 (79%) patients with an indication of valvular surgery, 3 (11%) died. 6 (22%) were contraindicated because of their neurological status, 2 (7%) were contraindicated for another cause and 16 (59%) had interventional endovascular treatment. Of the 27 (79%) patients with an indication of valvular surgery, 3 (11%) died. 6 (22%) were contraindicated because of their neurological status, 2 (7%) were contraindicated for another cause and 16 (59%) had interventional endovascular treatment. Of the 27 (79%) patients with an indication of valvular surgery, 3 (11%) died. 6 (22%) were contraindicated because of their neurological status, 2 (7%) were contraindicated for another cause and 16 (59%) had interventional endovascular treatment.

Conclusion: Patients with ICH had a higher mortality in 1-year mortality in patients less than 65 years old, but not in older patients. The predictors of ICH in infective endocarditis are: thrombocytopenia, low vitamin D level and hyperhomocysteinemia. The markers of thrombocytopenia, low vitamin D level and hyperhomocysteinemia were significantly associated with ICH. The markers of thrombocytopenia, low vitamin D level and hyperhomocysteinemia were significantly associated with ICH. The markers of thrombocytopenia, low vitamin D level and hyperhomocysteinemia were significantly associated with ICH. The markers of thrombocytopenia, low vitamin D level and hyperhomocysteinemia were significantly associated with ICH. The markers of thrombocytopenia, low vitamin D level and hyperhomocysteinemia were significantly associated with ICH.

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Intracranial haemorrhagic complications of infective endocarditis
E. Salaün1, G. Habib2, Y. De Lelley1, S. Hubert2, M. Sumian1, N. Michel1, A. Riberi1, D. Raoult1, F. Collart1, F. Thumy3, 1Département de Cardiologie, Hôpital Timone, Aix-Marseille Univ, Marseille, France; 2Service de Chirurgie Cardiaque, Hôpital Timone, Aix-Marseille Univ, Marseille, France; 3Service de Chirurgie Cardiaque, Hôpital Timone, Aix-Marseille Univ, Marseille, France; 4AP-HM - Hospital La Timone, Marseille, France
Purpose: The Intracranial Haemorrhages (ICH) represent up to 30% of neurolog- ical complications of endocarditis. They are due to three mechanisms: the haem- orrhagic conversion after cerebral embolism, the rupture of an intracranial infect- ious aneurysm (ICA) and the septic erosion of the arterial wall without infectious aneurysm. These complications lead to an excess mortality and complicate the achievement of valvular surgery. We aimed (i) to determine predictors of ICH, (ii) to describe their management and prognosis in a reference centre. Methods: In a retrospective single centre study, conducted from 2001 to 2012, all consecutive patients with definite infective endocarditis were included. Clnical and echocardiographic data were collected. Results: Among the 533 patients included, 34 (6.4%) experienced ICH. We found 12 (2.3%) intracranial haemorrhagic conversions, 11 (2.1%) rupture of ICA, and 11 (2.1%) septic erosion of the arterial wall without ICA. Multivariable analysis identified male gender (OR:2.9; 95% CI, 1.02-8.2; p=0.04), thrombocytopenia (OR, 3.2; 95% CI, 1.5-7.0; p<0.001) and the presence of a previous cerebral embolism (OR, 4.9; 95% CI, 2.3-10.5; p<0.005) as the main predictors of ICH. Among the patients with ICH, 4 (15%) died because of this complication; 19 (56%) were treated medically, 7 (21%) had a neurosurgical procedure and 3 (9%) had an interventional endovascular treatment. Of the 27 (79%) patients with an indication of valvular surgery, 3 (11%) died. 6 (22%) were contraindicated because of their neurological status, 2 (7%) were contraindicated for another cause and 16 (59%) were operated (8 during the antibiotic period [median time = 23 days after the identification of the antibiotic period, [median time = 85 days after the identification]). No postoperative neurological deterioration was observed.

Conclusion: The predictors of ICH in infective endocarditis are: thrombocytopenia, normal serum vitamin D level and no previous embolic event. A surgical indication persitence, the presence of an ICH is not always a formal contraindication and must be managed by a multidisciplinary approach.

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Fungal endocarditis: clinical predictors for early diagnosis aiming at better outcome
M.S. Meshael1, K. Said1, W.A. Arnoussy1, M. Amany2, M. Hosny1, H.H. Rikk1, 1Cairo University Hospitals, Department of Cardiovascular Medicine, Cairo, Egypt; 2Cairo University, Department of Clinical Pathology, Cairo, Egypt
Purpose: To study the clinical characteristics of patients with definite fungal en- docarditis (FE) aiming at detecting clinical predictors for early diagnosis. Fungal endocarditis is a devastating disease that is associated with multiple morbidities and high mortality. Diagnosis is difficult and usually very late. Early diagnosis and treatment may result in better outcome.

Method: Retrospective analytic study that included 232 patients with definite IE in the period between February 2005 and September 2011. Results: Among the 232 patients had FE. The whole group was relatively young with mean age of 35 (13-74) in FE and 28.5 (15-50) in non-FE group. In the FE group. 22 cases had aspergillus, 6 cases had candida [71% vs. 13.9%, p<0.001] and 3 had other fungi. Norris RHI was less prevalent in FE group (9.7% vs 42.8%, p<0.01; OR: 0.1, 95% CI = 0.04-0.49). The FE group had more cardiac protheses [74.2% vs 23.8%, p<0.001; OR: 9.18, 95% CI = 3.8-21.9]. Late PVE was more prevalent among FE group [84% vs 38%, p=0.059], late PVE was more common in non-

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Diabetes is a risk factor for septic shock in left-sided infective endocarditis
C. Olmos1, I. Vilacosta1, C. Ferreira1, C. Fernandez1, E. Pozo1, C. Sarria2, D. Vivas1, J. Lopez3, C. Ortiz3, J. A. San Roman3, 1Hospital Clinic San Carlos, Cardiovascular Institute, Madrid, Spain; 2University Hospital La Princesa, Madrid, Spain; 3Institute of Heart Sciences, ICICOR, University Clinic Hospital, Valladolid, Spain
 Aim: To examine the impact of diabetes mellitus (DM) in the in-hospital outcomes in a large cohort of patients.
 Methods: We studied 594 consecutive episodes of left-sided IE diagnosed at three tertiary centers. They were classified into two groups: Group I (n=114), episodes in patients with DM; and Group II (n=480), episodes in patients without DM. The influence of DM therapy on patients' outcome was retrospectively analyzed.
 Results: Compared to non-diabetic patients, diabetic patients were older (67±10 vs 60±15; p<0.001), less frequently males (53.8% vs 67.7%; p=0.004), and they...