highest statistical correlation with mortality outcomes in our sample. Therefore, a new risk score composed of these three variables that stratified the population in three mortality risk classes was created. Our results show that this risk score performed better in a prediction of in-hospital and 30-day mortality (AUC 0.82 95% CI 0.76–0.89 and AUC 0.79 95% CI 0.71–0.86, respectively) than the CardShock score (AUC 0.72 (95% CI 0.64–0.78), in our cardiogenic shock population (Figure 1).

Multivar. logistic regression analysis

<table>
<thead>
<tr>
<th>Variable</th>
<th>HR</th>
<th>95% CI</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.07</td>
<td>1.03–1.12</td>
<td>0.001</td>
</tr>
<tr>
<td>LVEF on admission</td>
<td>0.94</td>
<td>0.91–0.98</td>
<td>0.06</td>
</tr>
<tr>
<td>Lactate</td>
<td>1.23</td>
<td>1.11–1.37</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>CardShock score</td>
<td>1.79</td>
<td>1.38–2.33</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

AUC of the new score and CardShock score

Conclusions: The use of a simplified score is equally or even more reliable than CardShock risk score for the prediction of in-hospital mortality in pt with CS. This simplified score can be calculated in few minutes and is highly accurate, allowing to decide the best treatment options without further delay.

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Prognostic value of the combination of simple risk index and model of end-stage liver disease excluding INR (MELD-XI) scoring system in patients admitted for acute decompensated heart failure


Background: Increased heart rate (HR) and low systolic blood pressure (SBP) are associated with adverse clinical outcomes in patients admitted for acute decompensated heart failure (ADHF), and simple risk index (SRI) based on easily assessible clinical characteristics (age, HR, and SBP) provides prognostic information. On the other hand, cardiohepatic interactions have been a focus of attention in heart failure, and a model of end-stage liver disease excluding INR (MELD-XI), a robust scoring system of liver dysfunction, has been shown to be useful for prediction of poor outcome in ADHF patients. However, there is no information available on the prognostic value of the combination of SRI and MELD-XI score in ADHF patients.

Methods and results: We studied 299 ADHF patients, and obtained clinical characteristics, conventional hemodynamic parameters and laboratory data. SRI was calculated as (HR × age/10²) × SBP. MELD-XI score was calculated by the formula: 5.11 × ln(bilirubin) +11.79 × ln(creatinine) + 9.44. During a follow up period of 5.1±4.3 yrs, 71 patients had cardiovascular death (CVD). At multivariable Cox analysis, SRI (p=0.0009) and MELD-XI score (p=0.0003) were significantly associated with CVD, independently of serum sodium level and prior heart failure hospitalization. The patients with both greater SRI (≥33.7: AUC 0.607 [0.531–0.682]) and MELD-XI score (≥12: AUC 0.70 [0.64–0.77]) had a significantly increased risk of CVD than those with either greater SRI or MELD-XI score and none of them (44% vs 23% vs 10%, p<0.0001, respectively).

Conclusion: The combination of SRI and MELD-XI score might be useful for stratifying patients at risk for CVD in patients with ADHF.

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Age-related differences in characteristics and management of acute decompensated heart failure in Japan: insights from the kyoto congestive heart failure registry

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Background: The population of elderly patients with heart failure (HF) is growing, leading to increasing rates of various comorbidities.

Purpose: The purpose of this study was to provide information about the substantial age-related differences in clinical characteristics and management of acute decompensated heart failure (ADHF) in an updated multicentre registry.

Methods: Baseline data of consecutive patients with ADHF in 19 participating centres were collected prospectively from November 2014 to March 2016 (Kyoto Congestive Heart Failure Registry). The cohort consisted of 4065 patients who underwent heart failure-specific treatment with intravenous drugs within 24 hours after hospital admission. We evaluated the characteristics, management, quality of care provided, and in-hospital outcomes according to the age group (age <65 years [n = 508], 65–74 years [n = 748], 75–84 years [n = 1474], and >85 years [n = 1334]). Comparison among the groups was performed by using Pearson chi-square test.

Results: In the entire population, 55.2% were male and the median age was 80 years (interquartile range, 72–86 years). According to age group, the prevalence of females increased (<65 years, 24.8%; 65–74 years, 32.8%; 75–84 years, 42.8%; and >85 years, 61.2%; p<0.01), along with hypertension as underlying heart disease (20.7%, 21.9%, 23.0%, and 27.9%, respectively; p<0.01), atrial fibrillation at presentation (24.3%, 33.7%, 38.4%, and 38.7%, respectively; p<0.01), chronic kidney disease (31.5%, 39.5%, 47.0%, and 49.9%, respectively; p<0.01), and ejection fraction of ≥50% (21.5%, 35.1%, 46.7%, and 52.0%, respectively; p<0.01). In-hospital mortality was high according to age group (<65 years, 3.2%; 65–74 years, 4.9%; 75–84 years, 6.0%; and >85 years, 9.7%). Similarly, the length of hospital stay was long. At hospital discharge, among the entire cohort and patients with reduced ejection fraction, those who were aged were less likely to receive angiotensin-converting enzyme inhibitors, or aldosterone receptor blockers and beta-blockers (Figure 1A and B).

Conclusion: Substantial age-related differences in patient characteristics, outcomes, and management of ADHF were found. Although the prognostic impact of the differences in the management remains to be elucidated, this study highlighted the actual care received by elderly hospitalized patients with ADHF in the real-world clinical practice.