of care gaps was determined in all patients diagnosed with moderate to severe CHD. A care gap was present if no outpatient visit was registered in the Hospital Information System. Multiple logistic regression models were used to identify demographic, clinical and organizational characteristics associated with the occurrence of MA and care gaps, respectively.

Results: In the 2-year period, 3,459 outpatient visits were scheduled for 2,098 unique patients (median age 27y; 53% men). Overall, 8% of scheduled visits were characterized by an MA, occurring in 11 unique patients. Within the group of patients with MA, 80% had 1 MA, 19% had 2 MAs, and 1% failed to show up for 3 consecutive visits. Multivariable logistic analysis showed that first MAs were more common in men (OR=1.54; 95% CI: 1.17–2.06), in patients without a history of cardiac procedures (OR=1.44; 95% CI: 1.06–1.94), and for morning visits (OR=1.41; 95% CI: 1.08–1.88). About 6% of patients with moderate to complex CHD had a care gap during the 3.5 observation period. Logistic regression analysis demonstrated that patients who had at least 1 MA had a 17 times greater likelihood of experiencing a longer term care gap (OR=17.1; 95% CI: 10.6–27.5).

Conclusion: Non-attendance at outpatient clinics is a common problem encountered in patients affected with a chronic condition. Such MAs are a major source of inefficiency and disrupt the healthcare process. This study demonstrated that MA occurs in at least 1 in 10 patients with moderate to complex CHD. The likelihood of having a care gap was 17 times greater if patients had a prior MA. These results help us to identify patients prone to MA and facilitate us to improve the organization of ACHD care. Based on these findings extra attention should be given to patients not showing up for their visit. The effectiveness of interventions preventing MA, such as SMS-reminders, should be explored.
P2108 | BEDSIDE
Effects of white coat hypertension on heart rate recovery and blood pressure response during exercise testing
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Background: Increased sympathetic activity is one of the proposed mechanisms underlying exaggerated blood pressure (BP) response to exercise (EBPR). Heart rate recovery (HRR) is a simple non-invasive measurement analyzing autonomic nervous dysfunction, and has been shown to predict cardiovascular mortality. We aimed to the association between HRR and EBPR in patients with hypertension. Methods: A total of 409 consecutive patients who simultaneously underwent Treadmill test and 24-hours ambulatory BP monitoring (ABPM) were included to this cross-sectional case-control study. Patients were classified according to the ABPM: 147 patients with hypertension with dipper pattern (dipper), 140 patients with hypertension with non-dipper pattern (non-dipper) and 71 normotensive controls. EBPR was defined as a peak exercise systolic BP > 210 mmHg in men and > 190 mmHg in women. HRR was defined as peak heart rate minus heart rate after a 1-minute recovery; abnormal HRR was defined as > 12 beats/min. These parameters were compared with respect to occurrence of EBPR.

Results: Compared to the normotensive subjects, mean values of systolic and diastolic BP at baseline, peak exercise, and the first minute of the recovery were significantly higher in the subjects with white coat hypertension, dipper and non-dipper groups. HRR values were significantly lower (p < 0.001) in subjects with white coat hypertension and both hypertensive groups when compared with normotensive subjects, especially in non-dipper. There was a significant positive correlation between the decrease in systolic BP during the recovery and degree of HRR in individuals without EBPR (r = 0.12, p = 0.032), however, such a correlation was not observed in subjects with EBPR (r = 0.08, p = 0.471). Furthermore, in patients with white coat hypertension, there was a significant negative correlation between the decrease in systolic BP during the recovery and degree of HRR (r = -0.292, p < 0.004). The percentages of HRR and EBPR were significantly increased in patients with white coat hypertension (35.3% and 33.3%, respectively). In multivariate logistic regression analyses, HRR and resting systolic BP were the only determinants associated with the occurrence of EBPR.

Conclusions: Indicating impaired autonomic reactivation and higher prevalence of EBPR indicating increased sympathetic activation suggest that these autonomic dysfunctions could be the important future cardiovascular risk factors in subjects with white coat hypertension.

P2109 | BENCH
Peculiarities of haemostasis in different types of 24 hours day’s profile of blood pressure in hypertensive patients
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There is a high probability of thrombotic complications in the different types of 24 hours day’s profile of blood pressure (BP) in patients with essential hypertension. That is why it is important to find out the haemostasis indices changes depending on 24 hours day’s profile of BP. Today, there are only a few reports on haemostatic features in such patients. It was examined 127 middle-aged (45–59 years) hypertensive subjects, stage II and 93 elderly (60–74 years) patients. All individuals had 24 hour ambulatory blood pressure monitoring by ABPM-04. And they were divided into 2 groups of 24 hours day’s profile of BP: dippers if reducing of BP was enough at night (diurnal variation), and non-dippers if there was a little decrease of BP at night (Diurnal Index < 10%). 15 middle-aged and 15 elderly healthy volunteers were included in the study and venous blood samples were obtained. Spontaneous and induced platelet aggregations were determined. Platelets were activated with ADP, adrenaline and analysed by optical aggregometry (SOLAR AP-2110). Plasma haemostasis was defined with hemocoagulometer Amelung KC 1A. Increase in aggregation activity of middle-aged hypertensive patients was found in the group of dipper and non-dipper by means of amplitude of aggregation. The amplitude of ADP in patients with ADP was 1.9 (p < 0.05) fold higher compared with healthy adults and 2.3 (p < 0.001) times higher in non-dipper. The increase of the ADP-induced aggregation in non-dipper group by 20.9% (p < 0.05) was revealed compared with the group of dipper; slope accelerated by 3.1% (p < 0.05).

The amplitude of spontaneous aggregation in elderly non-dippers was 1.7 (p < 0.05) times higher compared with dippers and with ADP increased by 45.3% (p < 0.05) compared with dipper subjects. The time of the maximal aggregation during the adrenalin-induced aggregation in non-dipper group increased by 43.9% (p < 0.05). Significant increase of Fg was higher in elderly non-dipper subjects compared with healthy individuals and was 3.8±1.3 g/l (p < 0.05). Antithrombin III (AT III) decreased by 10.7% (p < 0.05) in non-dippers compared with healthy subjects. So, there is increase in platelet aggregation in both groups of hypertensive patients. However, more significant changes are found in non-dippers. It means that the activation of platelet haemostasis in these individuals. Thus, platelet activity increases especially with ADP in elderly non-dipper patients versus dipper. In addition, the most significant changes are determined during spontaneous and adrenalin-induced aggregation with middle-aged subjects. Significant increase of Fg is found in elderly non-dipper patients compared with healthy volunteers. AT III is significantly reduced in the group of non-dipper compared with healthy adults.

P2110 | BEDSIDE
Aortic diameters and mild functional aortic regurgitation in hypertensive and normal subjects
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The association between aortic root diameter and aortic regurgitation in hypertensive and normotensive subjects is still disputed, and the underlying mechanisms are not yet fully elucidated. We aimed to investigate the relationship between aortic root diameter and trivial to mild functional aortic regurgitation (FAR) in newly diagnosed, never-treated hypertensives compared with healthy normotensives. Material and methods: A total of 182 52-year-old hypertensives and 232 age- and sex-matched normotensive individuals were included in the study. Anthropometric and office blood pressure (BP) measurements, echocardiography, and carotid stiffness assessment were performed in all of the participants. Aortic measures for annulus, sinuses of Valsalva, sinotubular junction and ascending aorta were taken in late diastole according to the leading-edge method. Arterial stiffness was assessed using the Aloka color Doppler system (ProSound Alpha 10 ultrasound system) with a 7.5 MHz linear array probe and a high-resolution echo-tracking subsystem (Echo-track) that allows for the assessment of local arterial stiffness, deriving the pressure-radius curve of the artery, and calculating the local stiffness from the time delay between two adjacent distension waveforms. Results: Hypertensive patients had significantly higher body surface area (BSA), mean arterial pressure, and pulse pressure (p < 0.0001) than normotensive subjects. Annulus and sinotubular junction diameters adjusted for confounders and indexed to BSA were significantly higher in hypertensives than in normotensives. The prevalence of FAR was higher in hypertensives (34.8% vs. 15.4%, p < 0.0001). Among the hypertensives, no difference in aortic diameters was found between patients with or without FAR, whereas normotensives with FAR had significantly larger aortic diameters. Prevalence of mild aortic regurgitation analysis, age, BSA, were independent correlated with all ascending aorta diameters; gender was independently related with ascending aorta diameters; gender was independently associated, in a negative way, with the sinuses of Valsalva, carotid Ep with sinuses of Valsalva and sinotubular junction and Zva, negatively, with sinuses of Valsalva. On logistic regression analysis, age and gender were independent predictors of FAR, and gender was independently associated with FAR in a negative fashion. Age and BP among the hypertensives were the main determinants of FAR. Conclusions: Hypertensive patients had smaller indexed aortic root diameter than normal subjects, but had a higher prevalence of trivial to mild FAR. The aging process is the main determinant of FAR in both groups, but high BP also plays an important role in hypertensives.

P2111 | BEDSIDE
Age and gender related differences in invasive central pulsatile hemodynamics versus. non-invasive brachial pressures in a large arab population
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Background: While central aortic pulsatile hemodynamic indices are well established as independent prognosticators in various ethnic populations, currently there are no data on these important measures in an Arab cohort. Methods: We performed retrospective analyses on invasive central aortic and simultaneously measured non-invasive brachial pressures in some 2900 patients referred for coronary angiography to the Cardiothoracic Catheterization Laboratory at King Abdul Aziz Cardiac Centre, King Abdul Aziz Medical City, Riyadh, Saudi Arabia between the years 2010 and 2016. Amplification of the pulse was calculated as pulse pressure amplification by subtracting aortic pulse pressure (PP) from brachial PP, and also as systolic pressure amplification by subtracting aortic systolic from brachial systolic blood pressure (BP). We stratified the central aortic