rates of young, middle-aged, and elderly patients were 1%, 2%, and 5%, respectively (P < 0.01). Annual adverse arrhythmic event rates were similar in the three age groups at ~1% (P<0.9). Independent predictors of mortality in young patients were age, female sex, volume of alcohol injected during ASA, and residual left ventricular outflow tract gradient.

Conclusions: ASA in younger patients with obstructive HCM was safe and effective for relief of symptoms at long-term follow-up. We propose that the indication for ASA can be broadened to younger patients.

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Mitral valve replacement at time of myectomy for symptomatic obstructive hypertrophic cardiomyopathy
Background: Surgical myectomy (SM) is the definitive treatment for symptomatic drug-refractory hypertrophic obstructive cardiomyopathy (HOCM). Isolated SM is effective in majority with minor requiring additional mitral valve repair (MVRr). Mitral valve replacement (MVRr) is largely avoided due to long-term complications of prosthetic valves. We aimed to examine temporal trends, clinical profile and outcomes of concomitant SM+MVRr in comparison to SM+MVRr.

Methods and results: From 2003–2011, 1557 and 743 HOCM patients underwent SM+MVR or SM+MVRr, respectively as reported in Nationwide Inpatient Sample database. Number of SM+MVR and SM+MVR operations increased during recent period (OR=1.06; 95% CI=1.04-1.08; and OR=1.25–1.29; p<0.001 for both). Compared to SM+MVR, those with SM+MVRr were older (63±13 vs 58±14 years) and had their surgery more often at rural (2.9%-vs-0%), non-teaching (66%-vs-72%) and Southern Western (57%-vs-27%) hospitals (all p<0.01). The surgery was performed more likely (8.2% vs 4.7%) rate of any adverse event (57%-vs-44%), rate of any adverse event (57%-vs-44%), length of stay (141±11-vs-10±10 days), complete heart block (17%-vs-9%) and permanent pacemaker implantation (16%-vs-5%) were higher in those with SM+MVR (all p<0.001). Other common findings among SM+MVRr were atrial fibrillation (44%), ventricular tachycardia (7%), SA node dysfunction (7%) and ventricular fibrillation (2.3%). Cardiac adverse events in SM+MVR included acute CHF (6%), cardiogenic shock (5%), cardiac arrest (3%) and need for intraaortic balloon pump (5.4%) or mechanical ventilation (16.2%). Periprocedural complications included acute left renal failure (1%), vascular injury (11%), blood transfusion (8%), sepsis (7%), and stroke (5%).

Conclusion: Geographic and hospital characteristic differences were noted in rates of MVRr and MVRr at time of SM in HOCM persistently over the years. Some baseline differences existed between two groups and significantly higher rates of adverse outcomes, including hospital mortality, was observed in those with MVRr. Higher observed rate of MVRr compared to MVRr raises significant concern regarding best practices in management of HOCM.

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The Portuguese registry of hypertrophic cardiomyopathy (Pre-HCM): global results
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Background: The present study shows excellent safety and efficacy outcomes associated with septal reduction strategies in a high-flow HCM institution with moderate procedural volume. Perioperative mortality was comparable to that of major surgical centers. SM showed better long-term results than ASA in the present study, although this finding must be weighed against a more adverse baseline clinical profile of the ASA population.

Methods: The methods were performed by trained operators. Medical and instrumental data were acquired from pre-operative and follow up (FU) records.
Results: Patients were referred for invasive management at a mean age of 53±15 years and 67 (53%) were male. SM patients were younger (48±15 vs 58±13 years, p<0.01), had lower L VOT peak gradient (52±31 vs 70±33 mmHg, p<0.01), had lower L VOT peak gradient (52±31 vs 70±33 mmHg, p<0.01), and lower prevalence of atrial fibrillation (15% vs 41%, p<0.01). Postoperative values were lower in SM patients than the ASA group (11±10 vs 22±21 mmHg, p<0.001). ICD implantation rate for primary prevention was lower in SM patients (9% vs 34%, p<0.05). At 5 years, 66% of patients were alive, with a cardiac mortality rate of 1.3%/year. At the end of FU, the probability of a combined endpoint including cardiac mortality and re-intervention was 33.3% for ASA and 4.2% for SM (OR=-11.3, 95% CI=3.1 to 41.2; p<0.001). Conversely, cardiac mortality alone did not differ between the two groups.

Conclusions: The present study shows excellent safety and efficacy outcomes associated with septal reduction strategies in a high-flow HCM institution with moderate procedural volume. Perioperative mortality was comparable to that of major surgical centers. SM showed better long-term results than ASA in the present study, although this finding must be weighed against a more adverse baseline clinical profile of the ASA population.

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Outcomes of septal reduction therapies for obstructive hypertrophic cardiomyopathy in a high-flow referral centre with moderate volume procedural programmes
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Background: Surgical myectomy (SM) and alcohol septal ablation (ASA) decrease left ventricular outflow tract (LVOT) gradient in hypertrophic obstructive cardiomyopathy (HOCM) with durable symptom relief and low mortality when performed in experienced centres. Many HCM centres of excellence, however, are not primarily focused on invasive procedures and their interventional volumes are moderate. Yet, limited literature exists looking at outcomes of septal reduction therapies in such setting.
Purpose: To examine outcomes of septal reduction strategies for obstructive HCM at our institution, a long-standing high-flow referral centre with moderate volume procedural programmes; to examine the historical trends of referral to ASA vs SM over time.
Methods: A total of 125 HOCM patients (8% of the total HCM population) under-went SM or ASA in our institution from 1999 to 2015 at our centre. All procedures were performed by the same experienced operators. Medical and instrumental data were acquired from pre-operative and follow up (FU) records.
Results: Patients were referred for invasive management at a mean age of 53±15 years and 67 (53%) were male. SM patients were younger (48±15 vs 58±13 years, p<0.01), had lower LVOT peak gradient (52±31 vs 70±33 mmHg, p<0.01) and lower prevalence of atrial fibrillation (15% vs 41%, p<0.01). ASA was the prevalent treatment from 1999 to 2005 whereas SM largely predominated after 2005. At 38 days, 2 (1.6%) patients (one per treatment modality) died. 12 (9.6%) re-}