prevalence, scientific evidence is scarce and studies are needed to determine if IEAP could be useful in these individuals.

Objectives: We sought to describe the clinical course and microbiological profile of BAV and MVP patients with IE and compare them with those of patients with and without IEAP indications.

Methods: Data from the GAMES IE registry involving 27 Spanish hospitals were analyzed. From January 2008 to March 2015, 3120, consecutive IE patients were prospectively included in the registry. We selected: high-risk patients with indication of IEAP (Group 1, n=1115), patients without indication of IEAP (Group 2, n=1876), and patients with BAV (n=48) and MVP (n=80). Microbiological characteristics and adverse events due to IE during hospitalization were analyzed. BAV and MVP patients were compared to Groups 1 and 2. (Figure)

Results: BAV and MVP patients exhibited higher incidence of Streptococcus viridans IE than patients from Group 2 (26.5 vs 11.5%, p < 0.01) and (33.8 vs 11.5%, p < 0.01), respectively. Moreover, BAV and MVP patients had a higher percentage of IE from suspected odontogenic origin in comparison to Group 2 (14.3 vs 5.2%, p < 0.01) and (17.5 vs 5.2%, p < 0.01), respectively. BAV patients suffered more intraventricular complications (53.1 vs 31.7%, p < 0.01) and underwent cardiac surgery more frequently than Group 1 (73.5 vs 42.2%, p < 0.01). MVP patients also showed more intracardiac complications than Group 1 (45 vs 31.7%, p < 0.01). However, there were not statistically significant differences in cardiac surgery between both groups (p = 0.541)

81.7% and was lowest in the oldest age group (Figure 1). Factors associated with a higher likelihood of returning to the workforce were younger age (18–40 versus 56–60 years; odds ratio (OR), 2.84; 95% confidence interval (CI), 1.77–4.56) and higher level of education (higher educational level versus basic school; OR, 3.96; 95% CI, 1.55–10.1) and income (highest quartile versus lowest; OR, 2.92; 95% CI, 1.74–4.91). Longer length of stay (−90 versus 14–30 days; OR, 0.33; 95% CI, 0.16–0.66), a history of stroke (OR, 0.44; 95% CI, 0.27–0.70), malignancy (OR, 0.41; 95% CI, 0.24–0.70), and chronic obstructive pulmonary disease (OR, 0.27; 95% CI, 0.13–0.57) were associated with a lower likelihood of returning to the workforce.

Figure 1. Distribution of outcomes at 1-year follow-up in patients available to the workforce prior to first-time IE hospitalisation for infective endocarditis.

Conclusion: Seven out of 10 patients employed prior to first-time IE hospitalisation returned to the workforce one year after discharge. Younger age, higher socioeconomic status, and absence of major comorbidities were associated with a higher likelihood of returning to the workforce.

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Enterococcus faecalis endocarditis: prognostic factors, and 1-year survival vs propensity score matched patients with streptococcal endocarditis
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Background: Enterococcus faecalis is a common cause of infective endocarditis (IE). Only limited data on predictors of mortality exists and no studies have compared survival in matched groups of Enterococcus faecalis IE and streptococcal IE.

Purpose: To investigate predictors of 1-year mortality in Enterococcus faecalis IE patients and compare 1-year survival to a group of matched patients with streptococcal IE.

Methods: Prospective cohort study of consecutive patients with left-sided IE. Predictors of 1-year mortality were assessed with a multivariable Cox proportional hazard model with stepwise variable selection and inverse probability of treatment weighting to adjust for surgery. One-year survival in native valve Enterococcus faecalis IE was compared to a group of streptococcal native valve IE propensity score matched on age, sex, diabetes, chronic renal failure, history of cancer, active cancer, history of neurological disease and known mitral or aortic valvular disease.

Results: In the cohort of 146 Enterococcus faecalis IE patients the mean age was 69±11 years. 82% were men and the mean Charlson Comorbidity Index was 2.1±1.8. Reduced left ventricular ejection fraction (LVEF) at baseline, diabetes, large vegetations (>15 mm) and heart failure as a complication during the course of treatment were all independent risk factors of 1-year mortality (table 1). When comparing survival in the 98 native valve EF IE patients with 243 native valve streptococcal IE patients the crude Kaplan Meier survival curve showed significantly lower one-year survival in Enterococcus faecalis IE patients (Figure 1A). In contrast, when the two propensity score matched cohorts were compared, survival did not differ, Figure 1B.