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	In-hospital mortality	30 days mortality	1 year mortality							
APE group	Ischemic	Valvular	Hypertensive	APE group	Ischemic	Valvular	APE group	Ischemic	Valvular	
PAAT	p <0.01	p <0.01	NS	p <0.01	p <0.01	p = 0.02	p = NS	p <0.01	NS	p = 0.04
COV	92ms				95ms			98ms		

PAAT-pulmonary acceleration timeCOV-cut off valueNS-non statistically significant

Introduction: Modified peripheral systemic vascular resistance as etiopathogeny of APE is a theory that has already been accepted. Can be non-invasive echocardiographic assessment of high pulmonary vascular resistance (PVR) helpful in understanding the pathophysiology as well as in establishing the prognosis?
Purpose: Identifying the prognostic value of pulmonary acceleration time in pulmonary artery(PAT) in Acute Pulmonary Edema outside of an acute coronary syndrome (non ACS APE) of diversified ethiologies.
Methods: 92 patients with non-ACS APE consecutively hospitalized in our clinic between 01.01-31.12.2015, distributed and analyzed according to three etiologies, based on anamnesis, clinical and paraclinical data: ischemic, primary valvular and hypertensive (with preserved LVEF, without significant valvular or documented coronary artery disease). An echocardiography was performed on admission. We assessed also PAT. We assumed that this echo parameter when has semnificative decresed values, can express high pulmonary vascular resistance and does not depend on RV systolic function. We correlated this parameter, when pathological modified, with short, medium and long-term prognosis for entire group and according with ethiology. We identified cut-off values with prognostic value using a ROC curve analysis.
Results: In the entire group 63% patients have PAT < 105 ms. PAT has been statistically significant (SS) associated with short, medium and long term prognosis in the whole group($p < 0.01$)with cut off value(COV) 92ms, 95ms and respectivly, 98ms. The prognostic value changes depending on substrate and on the end-point term:SS for in hospital mortality($p < 0.01$) for ischemic and hypertensive substrate; for 30 days mortality for ischemic($p = 0.02$) and for valvular ethiology ($p = 0.04$) for 1 year mortality.
Conclusions: A decreased PAT was present in more than 50% of pts with non ACS APE and has proven an important prognostic value for short($p < 0.01$), medium($p < 0.01$) and long- term mortality($p < 0.01$) in entire group with COV of 92ms, 95ms and 98 ms. The prognostic role changed according with etiology and endpoint term. High pulmonary vascular resistance play an important in role in APE patophysiology and PAT can be an usefull echo-parameter with diagnostic and prognostic value.

Acute Heart Failure - Treatment

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Digoxin and Prognosis of Heart Failure in Older Patients with Preserved Ejection Fraction: Importance of Heart Rate

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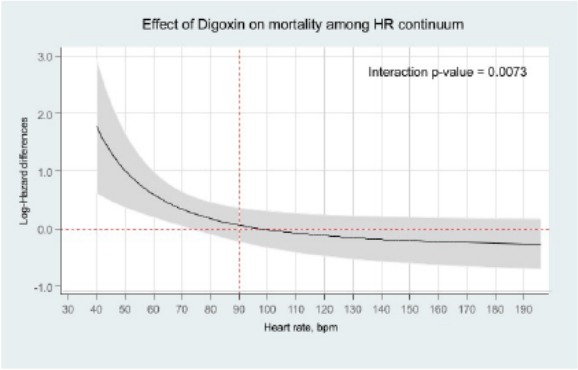
On behalf of: RICA register. SEMI

Background: The value of digoxin in heart failure (HF) remains controversial, particularly in patients with preserved ejection fraction (HFpEF). This study evaluated the 1-year risk of events after digoxin treatment for acute heart failure (AHF) in patients >70 years old with HFpEF.



Digoxin and mortality across heart rate

Methods: 1883 patients were included in this analysis (mean age, 82 years). The main endpoints were all-cause death and the composite of death and/or HF re-admission within 1 year. Cox regression analysis was used to evaluate the association between digoxin treatment and prognosis.
Results: 401 patients received digoxin treatment; of these, 86% had atrial fibrillation. The mean baseline heart rate was 86 ± 22 bpm. At the 1-year follow-up, 375 patients (20.5%) died and 684 (37.3%) had composite endpoints. Patients treated with digoxin showed higher rates of death (3.21 vs. 2.44 per 10 person-years, $p = 0.019$) and composite endpoint (6.72 vs. 5.18 per 10 person-years, $p = 0.003$). After multivariate adjustment, digoxin treatment remained associated with increased risks of death (HR = 1.46, 95% CI: 1.16-1.85, $p = 0.001$) and the composite endpoint (HR = 1.35, 95% CI: 1.13-1.61, $p = 0.001$). A distinctive prognostic effect of digoxin was found across the heart rate continuum; the risks for both endpoints were higher at lower heart rates and neutral at higher heart rates (p of the interactions = 0.014 and 0.028, respectively).
Conclusions: In older patients with HFpEF discharged after AHF, digoxin treatment was associated with increased mortality and/or re-admission, particularly in patients with lower heart rates.

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Elegibility for sacubitril/valsartan utilization in acute heart failure

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On behalf of: EPICO

Background: Sacubitril/Valsartan represents a major breakthrough in the set of heart failure treatment, since it has improved risk of death and re-hospitalization after more than a decade without new perspectives. Despite of this, PARADIGM-HF trial has not investigated benefits of utilization among acute decompensated patients during their hospital phase.
Purpose: We sought to investigate and describe the proportion of elegible patients and reasons for non-elegibility for sacubitril/valsartan utilization among patients admitted for acute decompensated heart failure.
Methods: Cohort data from 543 patients admitted in a tertiary cardiac referral centre for acute systolic heart failure compensation (left ventricular ejection fraction <50%). All the data was collected from medical records. Heart failure was defined according the European Society of Cardiology (ESC) guidelines.
Results: The main reason for non-elegibility was left ventricular ejection fraction = 35% (34%; 171 individuals). 31.1% (155) of the patients had previous intolerance to angiotensin converting enzyme inhibitors or angiotensin receptor blockers and 7% (37) had hypotension during hospital stay (systolic blood pressure <90mmHg). Likewise, 37 patients (7%) had need for dialysis. At the end of the analysis, 36.5% (198) of the patients remained elegible for sacubitril/valsartan initiation during hospital phase.