Results

Outcomes were 156 survivors, 120 SCD and 70 non-SCD. Based on multivariate logistic regression analysis, 6 ECG parameters remained significant as SCD predictor in the final model, namely bundle branch block, abnormal P waves, QRS duration, QTc duration, TpTe interval and PR interval. Significant ECG parameters were combined into a risk score to enumerate prediction ability towards SCD and non-SCD. From our ECG risk score model, subject with [3] 2 ECG abnormalities had more than 3-fold increased risk for SCD (HR 3.739, 95% CI 1.703-8.211, P 0.001) and risk of SCD proportionately increased with increasing ECG abnormalities.

Conclusion

This cumulative ECG risk score model was independently associated with SCD and particularly effective for LVEF <40% where risk stratification model for remained scarce. These findings warrant further evaluation in prospective study to further clarify our outcome.

52.

Functional assessment of HFrEF patients under GDMT in a district hospital

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Background

Recent advancement and treatments have greatly improved the clinical outcome of heart failure patients. Proper assessment of patients functional capacity is a challenge in district hospital setting. 6 min walk test is a simple and well tolerated assessment which guides clinicians in management of patients along with other easily available modes of assessment.

Objective

Our study aim is to investigate the impact of GDMT for heart failure patients and the value of the 6 min walk test for functional assessment in a district hospital setting.

Method

Patients under heart failure clinic follow up of at least 6 months duration were recruited. The data and clinical parameters of the patients were collected and analyzed retrospectively.

Result

A total of 37 patients were recruited and evaluated. Their mean age is 44 and predominantly male at 80%. Our GDMT prescriptions at 6 months are ARNI/ACEi 88%, Beta blocker 97%, MRA 87% and SLGT2 43%. The mean LV ejection fraction was 28% during clinic enrollment. This improved to mean LV ejection fraction at 38% at 6th month follow up. At the time of first visit, 21.6% of patients had NYHA Class I, 59.5% had NYHA Class II, and 18.9% had NYHA Class III heart failure. 56.5% of patients have an improvement of > or = 1 NYHA class from baseline at 6-month follow-up. There was improvement in NYHA class. At the end of 6 months, 58.3% patients were classified as NYHA class I, while 41.7% were NYHA class II. Patients under follow up in HF clinics also showed improvement in 6MWT. The lowest value was 175 M at clinic enrollment, while the lowest value at 6 months follow-up was 250 M. The mean 6MWT also improved from 344 m at baseline to 386 m at 6 months.

Conclusion

GDMT has shown improvement in functional outcome of the patients. 6 min walk test is a useful and simple tool in assessment of heart failure patients and should be use along with other modes of assessment in HF clinics.

53.

Key characteristics and short term outcome of HFPEF patients – insights from MYHF Registry

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Introduction

Heart failure with preserved ejection fraction (HFpEF) is a global public health problem. There is scarcity of data about HFpEF-related acute decompensated heart failure (ADHF) in Malaysia.

Objective

This report aimed to describe the baseline characteristics of hospitalized HFpEF patients enrolled in Malaysian Heart Failure (MyHF) Registry.

Materials and methods

MyHF Registry is a prospective observational study recruiting hospitalized adult HF patients from 18 centres in Malaysia from 2019 to 2020. Recruited patients were admitted with a clinical diagnosis of HF by the attending physician with a minimum hospital stay of 24 h for stabilization before discharge.

Results

Of 2717 HF patients recruited in this registry, 2651 patients had complete LVEF analysis. Based on universal definition HFpEF as defined by LVEF≥50%, 21.6% ($n = 587$) was categorized as HFpEF. Compared to the overall cohort, our HFpEF patients were much older [mean age of 65.3 (SD 13.3) vs 60.1 (SD13.7); $p = 0.0001$], with 7 out of 10 (69.7%) was above 60 years old. More female was also being observed in HFpEF patients (53.5% vs 33.4%; $p < 0.001$). For comorbidities, hypertension was more common in HFpEF (76.8% vs 71.6%), similarly for atrial fibrillation/ flutter (21.0% vs 13.7%), and sleep disordered breathing (2.6% vs 1.2%). More HFpEF patients