Abstracts

S303

significantly associated with monitoring.

High Risk Discharged Inpatient Monitoring P value

History 30.6% 29.6% 0.94
Examination 5.6% 22.2% <0.05
ECG 11.1% 22.2% 0.30

Conclusion: Patients with syncope do not receive consistent guideline based cardiac monitoring and outpatient review. Future studies investigating clinician and patient factors that can improve guideline adherence are needed to address a potential treatment gap.

http://dx.doi.org/10.1016/j.hlc.2019.06.392

High-Dose Colchicine Therapy for Recurrent Idiopathic Pericarditis

K. Vaidya1,2, I. Wilcox1,2

1 Department of Cardiology, Royal Prince Alfred Hospital, Camperdown, Australia
2 Central Clinical School, Faculty of Medicine and Health, The University of Sydney, Sydney, Australia

Background: Recurrences of idiopathic inflammatory pericarditis after an index event can cause substantial patient morbidity, and the need for corticosteroid therapy with its associated toxicities increases the risk of recurrence and harm. The anti-inflammatory medication colchicine is well-established in the treatment of recurrent inflammatory pericarditis at a maintenance dose (0.5 to 1 mg/day) for at least six months, with a favourable safety profile in most patients. However, despite this, recurrence rates remain as high as 30%.

Methods and Results: We report, for the first time, on the use of high-dose colchicine (1.5 to 3 mg/day in divided doses) therapy as a steroid-sparing strategy to further minimize recurrences and treatment-related morbidity. In a series of nine patients with recurrent idiopathic and significant recurrences and treatment-related morbidity after an initial trial of high-dose colchicine therapy, and four only required short periods of moderate doses during an acute flare.

Conclusion: We propose that in carefully selected and monitored patients, escalation to high-dose colchicine therapy, with a subsequent gradual downsituation after achieving remission, is a feasible and successful strategy to minimize recurrences whilst also avoiding, weaning off, or reducing corticosteroid requirements. This novel steroid-sparing approach needs to be further evaluated in an adequately powered, placebo-controlled randomised trial, with the study outcomes evaluating rate of recurrences but also accounting and adjusting for cumulative corticosteroid requirements.

http://dx.doi.org/10.1016/j.hlc.2019.06.393

Impact of Cardiovascular Risk Factors on Survival following Liver Transplantation: Results from the Australian & New Zealand Liver Transplant Registry

A. Koshy1,2, P. Cow2, B. Cailes1, J. Sajeev1, A. Teh2, H. Lim1, H. Han1, R. Jones2, A. Testro2, M. Byrne2, J. Ko1, D. Clark1, M. Yudi1, O. Farouque1

1 Austin Health Department of Cardiology & University of Melbourne, Heidelberg, Australia
2 Victorian Liver Transplant Unit, Heidelberg, Australia

Background: Cardiovascular (CV) death is a leading cause of long-term mortality following liver transplantation (LT). Identifying pertinent CV risk factors that impact on long-term survival may allow an opportunity for intervention.

Methods: Outcome data was prospectively collected for all adult LT performed in Australia and New Zealand between 1985-2017, from the Australian and New Zealand Liver Transplant Registry. Risk factors including hypertension, diabetes, age, sex, obesity (body mass index ≥30 kg/m²), pre-existing coronary artery disease (CAD) and non-alcoholic fatty liver disease aetiology were entered in a multivariable Cox model.

Results: Among 4,538 adult LT performed across 6 participating centres, 1,453 (31.6%) deaths occurred. This included 240 CV deaths (17%) that occurred over a median follow-up of 10.5 years (IQR: 4.9–17.9 years). On univariate analysis, age ≥50 years (log-rank test, p < 0.001), diabetes (p = 0.01) and obesity (p = 0.006) were associated with all-cause mortality. (Figure). After Cox multivariable adjustment, diabetes (Hazard ratio [HR] 1.4, 95%CI 1.07–1.8, p = 0.01) and age ≥50 (HR 1.5, 95%CI 1.2–1.9, p < 0.001) remained as independent predictors for all-cause mortality. Notably, pre-existing CAD did not predict long-term mortality (p = 0.24).

Conclusion: Presence of diabetes and age ≥50 independently increased the risk of long-term mortality following LT. Whether intensive risk factor modification in high-risk populations improves long-term survival after LT remains to be tested.