

of awareness of different aspects of management of heart failure leads to poor adherence to treatment which further adds to the healthcare cost.

Despite a number of evidence based medications being available, the utilization are not always satisfactory.

Objective:

We conducted a study to explore patients' understanding and adherence to Heart Failure (HF) medications at a general hospital setting.

Materials and Methods:

We prospectively studied from January 2018 till October 2018, 196 patients (outpatients plus inpatients) of HF at our hospital. The information was gathered by oral interview as well as using questionnaire.

Results There were 110 male and 86 female patients with average age of 54 years. The majority of patients (78%) were in NYHA class II and III and 72% of patients were from Outpatient visits.

15% of patients stopped or reduced the dose of diuretics on their own as they thought they didn't need them anymore or they were thought to interfere in their life style. 36 % patients believed that ACE Inhibitors or ARBs were for blood pressure and therefore they had either stopped or were intending to stop. 43 % patients were not keen on taking beta-blocker because of fear of various side effects and 12% of them already stopped the beta-blocker on their own. 56% of patients did not like the idea of increasing the dose of ACE Inhibitor , ARBs or beta-blocker to the maximum, mainly out of fear of side effects. In addition, 54% of the patients reported that they were not informed by the prescribing physician regarding the purpose and benefits of up titrating the dose of these medication. Patients were ignorant of the role of different HF medications such as Aldosterone antagonists (86%), ACE Inhibitor or ARBs (76%) , Beta blocker (70%). None of the patients who were on Ivabradine knew the role of the drug in HF but at the same time were not informed of any known side effects.

Conclusion Inadequate understanding and poor adherence to medications is a common problem among heart failure (HF) patients. as shown in our study. Inadequate adherence leads to increased HF de-compensation, reduced exercise tolerance, poor quality of life and higher risk for hospital admission and death. They all lead to increase in heart failure treatment and management costs.

Conflict of Interest None

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MID-WALL FIBROSIS AND OUTCOMES IN NON-ISCHAEMIC CARDIOMYOPATHY AND CARDIAC RESYNCHRONISATION THERAPY

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Background Non-ischaemic cardiomyopathy has been associated with better left ventricular (LV) remodelling and outcomes post-cardiac resynchronisation therapy (CRT) but

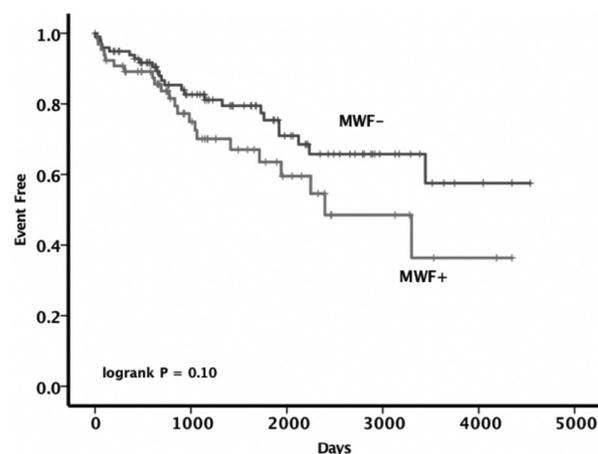
has separately been linked to poorer outcomes when associated with mid-wall fibrosis (MWF) on cardiac magnetic resonance. Therefore, we aimed to confirm the impact of MWF in patients with non-ischaemic cardiomyopathy and CRT.

Methods We retrospectively evaluated data from 164 consecutive patients with a diagnosis of non-ischaemic cardiomyopathy and CRT implants. Non-eligible patients were excluded (eg. ischaemic, amyloid or sarcoid cardiomyopathy, missing data). Patients with or without mid wall fibrosis (MWF+, n=69 vs MWF-, n=99), were compared and evaluated for major cardiovascular event (including all-cause mortality or hospitalizations for ventricular arrhythmias, heart failure or myocardial infarction) from time of CRT implant. Results were reported as mean \pm SD. $p \leq 0.05$ was deemed statistically significant.

Results Mean age of patient cohort was 66 ± 14 years with total follow-up duration of 1140 ± 1018 days. Between the groups, no significant difference in baseline demographics was observed in terms of age, gender, comorbidities (hypertension/diabetes), medication profiles, electrocardiographic measures (intrinsic rhythm and QRS duration). MWF+ demonstrated lower LV ejection fraction (28 ± 10 vs $31 \pm 13\%$, $p=0.02$) and higher LV end-systolic volume (211 ± 90 vs. 181 ± 96 ml, $p=0.05$) when compared to MWF-. However, there were no significant differences between MWF+ vs MWF- in terms of all-cause mortality (34% vs 24%, see Figure 1), or hospitalisations for ventricular arrhythmia (5% vs 2%) or heart failure (18% vs 22%), respectively.

Conclusion This retrospective study demonstrated that MWF+ was associated with lower LV ejection fraction and higher LV end-systolic volumes compared to MWF-. However, we observed no significant between-group difference in major adverse cardiovascular events. Further evaluation of this patient cohort in larger studies is warranted.

Conflict of Interest Nil



Abstract 94 Figure 1 Kaplan-Meier demonstrating no significant difference in all-cause mortality in patients with non-ischaemic cardiomyopathy and cardiac resynchronization therapy with mid-wall fibrosis (MWF+) vs those without fibrosis (MWF-) over follow-up