this finding in the absence of formerly known causes has not been extensively studied.

Objective: To describe the characteristics and clinical outcomes associated with an abnormal LVCR.

Methods: Searched PubMed, Embase database under the guidance of a trained librarian for the keywords “left ventricle/ventricle/myocardium” and “contractile reserve/contraction/contractility” and “prognosis/outcome/mortality/survival”. We selected 27 studies that satisfied the eligibility criteria and were summarised according to PRISMA protocol describing patients’ characteristics.

Results: There were 2435 subjects (66.8% men) categorised in four subgroups according to the pathophysiological process: dilated cardiomyopathy, ischaemic cardiomyopathy, valvular disease and miscellaneous. Dobutamine stress echocardiogram was the most commonly performed modality (69%) followed by exercise stress echocardiogram (17%), dipyridamole stress echocardiogram (7%), invasive haemodynamic measurement (4%) and dobutamine stress MRI (3%).(Fig. 1) A diverse range of indices were utilised to measure LVCR including \(\text{\delta}1\) LV ejection fraction (40.7%), \(\text{\delta}1\) wall motion score index (33.3%), \(\Delta\) stroke volume (11.1%), \(\Delta\) global strain rate (7.4%), \(\Delta\) Fractional area (3.7%).(Fig. 1) Most studies (96.2%) demonstrated a significant correlation between the absence of LVCR and raised cardiovascular events, cardiac death and all-cause mortality.

Fig. 1.

Conclusions: This study suggests an abnormal LVCR is associated with increased adverse outcome, regardless of the underlying cardiac pathology.

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Male: Barriers to Urgent Heart Transplant Refractory Cardiogenic Shock in a Young
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Sydney, Australia

valves following ease on adalimumab, as well as metallic mitral and aortic
anterior STEMI. His past history was notable for Crohn’s dis-
sion with a transplant centre regarding suitability and barriers
s before passing away.

Mortality for patients in refractory cardiogenic shock remains high despite modern supportive care. Early discus-
ion with a transplant centre regarding suitability and barriers
to transplant is essential; notably intra-cardiac infection does not
preclude heart transplant consideration.

Background: Heart failure with preserved ejection fraction (HFpEF) is a common disorder, associated with congestive
episodes, and/or symptoms attributable to heart failure. No
therapy has been shown to improve long-term outcomes. How-
er, as exertional intolerance is a major symptom
bden, numerous Phase II studies have utilised exercise end-
points as an indicator of benefit.

Methods: We undertook a quantitative review of studies published as of October 2016 by searching PubMed, Embase
and clinicaltrials.gov, combining terms related to the popul-
tion (i.e. HFpEF) with terms for the outcomes (e.g, VO2peak,
aerobic capacity, etc.). Random effects meta-analysis on the
mean difference in raw change scores was performed with
subgroup analysis for exercise and pharmaceutical studies.

Results: Five exercise and 10 pharmaceutical trials were
cluded aerobic based regimes performed 2-3 times per
week at 40-70% of VO2peak. Pharmaceutical trials examined
ivabradine, sildenafil, ACE-inhibition, angiotensin receptor
blockade, beta-adrenergic antagonists and mineralocorticoid
receptor antagonists. On average, exercise increased VO2peak
by 2.41 ml/kg/min, (95% CI: 1.8, 3.02) while pharmaceuti-
cal interventions did not exhibit any effect (-0.04 ml/kg/min,
95% CI: -0.64, 0.56). 6MWD was improved following exercise
by 39 m (95% CI: 13, 65), but not by pharmaceutical interven-
tion (4 m; 95% CI: -16, 7).

Conclusion: Exercise training exhibited a strong effect on
indices of functional capacity. In contrast, the pharmaco-
therapies tested thus far do not improve exercise tolerance.

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