

disease which is prognostically the most serious subtype of this group of disorders.

Methods: This presentation summarizes the classification, clinical manifestation, diagnosis, differential diagnosis and management of Sack-Barabas syndrome, based on systematic review of specialist literature dealing with this topic.

Results: Ehlers-Danlos syndromes are currently classified in a system of thirteen subtypes. Each EDS subtype has a set of clinical criteria that help guide diagnosis. Vascular Ehlers-Danlos syndrome (VEDS; EDS subtype 4; EDS IV; Sack-Barabas syndrome) is rare genetic connective tissue disorder of blood-vessels typically characterized by the association of unexpected vascular and organovascular fragility (arterial/ microvascular/ bowel/ gravid uterine rupture) with inconstant physical features as thin, translucent skin, easy bruising and acrogeric traits.

Conclusions: Awareness about this rare condition is essential for early recognition and therefore for the initiation of management and prevention of complications, often requiring treatment in a specialized vascular centre.

EP605 / #1008, TOPIC: ASA04 - CLINICAL VASCULAR DISEASE / ASA04-06 ANEURYSMS AND OTHER NON-ATHEROSCLEROTIC ARTERIOPATHIES, POSTER VIEWING SESSION.

TEMPORAL TRENDS IN MEDICAL CARDIOPROTECTIVE TREATMENT IN PATIENTS WITH ABDOMINAL AORTIC ANEURYSMS: A POPULATION-BASED NATIONAL COHORT STUDY

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Background and Aims : Patients with abdominal aortic aneurysmal (AAA) disease suffer high morbidity and mortality, driven mainly by cardiovascular comorbidity, and not the aneurysmatic disease itself. Initiation of cardioprotective therapy with statin and antiplatelets is recommended at AAA diagnosis. However, the implementation of recommendations over time is not well described. We aimed to provide up-to-date insights on temporal trends in the use of cardioprotective therapy in patients diagnosed with AAA.

Methods: Through national population-based health registries, we identified patients with an incident diagnosis of AAA from 2000 through 2018. By means of descriptive statistics, we characterized the development in prescription claims of statin and antiplatelet therapy. Analyses were stratified on year of diagnosis in the following intervals: 1999–2003, 2004–2008, 2009–2013, and 2014–2018.

Results: We identified 33,296 individuals with an incident diagnosis of AAA during 2000–2018. Mean age was 74 years. Prevalence of cardiovascular comorbidity (e.g., ischemic heart disease, cerebrovascular disease) ranged between 32.6% and 41.5%. The use of statins increased from 17.9% in 1999–2003 to 66.9% in 2014–2018, use of antiplatelets increased from 45.6% to 63.3%, and combined therapy with both statin and antiplatelets from 11.3% to 44.8%. Developments in medication use plateaued after 2013.

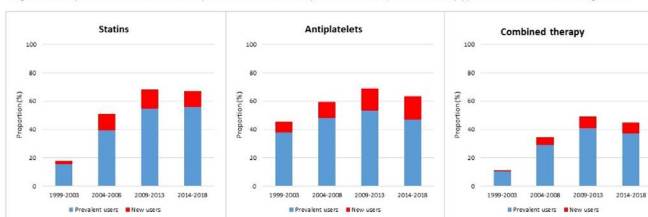
Conclusions: In patients diagnosed with AAA, implementation of cardioprotective therapy with statins and antiplatelets improved over time. However, despite a consensus endorsing intensified medical therapy, no further improvement was observed after 2013, and half of AAA patients were untreated with statin and antiplatelets from 2013 to 2018. Continuous quality improvement could focus on promoting optimal medical cardio protection.

Table 1. Baseline demographics and comorbidity of study cohort stratified by year of AAA diagnosis

	Period 1 1999-2003	Period 2 2004-2008	Period 3 2009-2013	Period 4 2014-2018
Demographics, % (N)				
N	6009	7784	9602	9998
Age, median (IQR)	73 (67-79)	73 (68-79)	74 (68-79)	74 (69-80)
Female	24.7 (1458)	25.1 (1950)	23.8 (2281)	23.5 (2351)
Any atherosclerotic cardiovascular disease				
Cerebrovascular Disease	10.4 (613)	10.7 (832)	9.1 (875)	8.9 (887)
Ischemic Heart Disease	24.3 (1439)	24.5 (1910)	21.7 (2080)	19.2 (1916)
Peripheral Arterial Disease	17.2 (1017)	15.0 (1168)	12.9 (1239)	11.0 (1102)
Comorbidity, other				
Hypertension	17.9 (1059)	26.8 (2084)	30.1 (2889)	30.8 (3084)
Diabetes	5.2 (308)	7.3 (571)	8.5 (819)	8.7 (867)
Heart Failure	9.9 (585)	9.6 (744)	8.1 (773)	7.9 (774)
Chronic Pulmonary Disease	12.5 (740)	13.2 (1025)	13.4 (1288)	14.4 (1440)
Atrial Fibrillation	9.6 (559)	11.5 (892)	11.6 (1112)	12.5 (1251)
Cancer	8.8 (522)	10.8 (844)	12.8 (1233)	13.9 (1394)
Venous Thromboembolism	2.4 (141)	2.6 (201)	3.0 (285)	3.8 (381)

IQR = Inter quartile range, n = number, AAA = abdominal aortic aneurysm

Figure 1. Proportion in medical cardioprotective treatment (statin and antiplatelet therapy) around time of AAA diagnosis.



Prevalent user: prescription claim within 365 to 1 days before AAA diagnosis. New user: prescription claim in treatment naive patients in the period from 0 to 90 days after AAA diagnosis.

EP606 / #500, TOPIC: ASA04 - CLINICAL VASCULAR DISEASE / ASA04-06 ANEURYSMS AND OTHER NON-ATHEROSCLEROTIC ARTERIOPATHIES, POSTER VIEWING SESSION.

SPECKLE-TRACKING TRANSESOPHAGEAL ECHOCARDIOGRAPHY IN THE MODERATE DILATATION AND ANEURYSM OF THE ASCENDING AORTA: PRELIMINARY RESULTS FROM PROSPECTIVE STUDY

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Background and Aims : The aortic size alone is insufficient predictor of the aortic-related events. In this regard, aortic wall stiffness also need to be evaluated for clearer understanding on the contributors of aortic-related complications. We compared global circumferential strain (GCS) and global circumferential strain/pulse pressure (GCS/PP) and fraction area change (FAC) in moderated dilated and aneurysmal ascending aorta (AA).

Methods: Twenty patients were enrolled in the prospective study. Of these, 9 patients (Dilatation group) presented with AA dilatation (45–50 mm) and 11 patients (Aneurysmal group) had AA aneurysm (>50 mm). Mean age of the participants was 65±9 years. All of the patients were candidates for AA surgery. Aortic wall stiffness parameters such as GCS, GCS/PP and FAC were assessed at 4 levels of the thoracic aorta by 2D