patients. Patients were referred for interventional catheterization \( (n = 12, 17.6\%) \), for surgery \( (n = 5, 7.4\%) \), for acute heart failure \( (n = 3, 4.4\%, 100\% \text{ type C}) \) or for medical follow-up. Complications [stroke \( (n = 2/12) \), heart failure \( (n = 10/12) \), arrhythmia \( (n = 7/12) \), pulmonary hypertension \( (n = 5/12) \), death \( (n = 1/12) \)] were mainly observed in C patients \( (P = 0.018) \). C and M patients had lower education level \( (14.3\%, 12.5\% \text{ vs. } 55.7\% \text{ had Baccalaureat, } P = 0.019) \). C patients had less access to driving license \( (P = 0.02) \). Only 1/3 of C patients had an active employment. Physical activity was lower in C patients \( (P = 0.02, \text{ none activity in } 87.5\% \text{ but } 57\% \text{ had previously contra-indicated to sport}) \). There was no significant difference between the three groups regarding antidepressant medication \( (8.2\%, P = 0.578) \), psychological follow-up \( (19.0\%) \).

**Conclusion.**— ACHD patients with complex heart disease have reached adulthood as survivors. Their medical past has impacted their social development and professional activity. Specific attention should be paid to the schooling of children with complex congenital heart disease.

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21

**Quality of life among children with congenital heart diseases: Comparative multi-center cross-sectional study**

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**Introduction.**— Very few comparative studies have yet reported health related quality of life (HRQoL) among children with congenital heart diseases (CHD).

**Method.**— We prospectively recruited children aged 8 to 18 with CHD (group 1, \( n = 282 \)) and same age randomized control population selected among schools (group 2, \( n = 164 \)). CHD were recruited in two tertiary care centers in France and Belgium. Thirty families refused to participate in group 1 and 150 in group 2. Primary outcome was the scoring for each dimension with Kidscreen-52 for children and Kidscreen-27 for parents (French version of the generic validated pediatric HRQoL questionnaire). Secondary outcomes were: severity class of CHD from 1 to 4 (from Uzark), cardiopulmonary exercise test \( (\text{VO}_2 \text{max}, \text{ anaerobic threshold, VE/VCO}_2 \text{ slope, oxygen uptake efficiency slope}) \), and PedsQL scoring (non-validated HRQoL generic questionnaire, French and Belgium versions, self and parents reports).

**Results.**— Two hundred and eighty-two children with CHD (sex ratio 1.9 — mean age 12.3 \( \pm 3 \)) and 164 children in schools (sex-ratio 1.1 — mean age 12.8 \( \pm 2.4 \)) were recruited. Both centers were comparable for most demographic and clinical data. In most dimensions self-reported QoL scores among children with CHD were not different from control group, except for physical well-being \( (\text{mean } 46.5 \pm 10.2 \text{ vs. } 49.9 \pm 8.6, P < 0.05) \). QoL in lower severity classes was not significantly different from controls. Children with severe CHD (class 4) had lower QoL in physical well-being \( (43.34 \pm 9.64, P < 0.05) \). In group 1, parents’ reported QoL was lower than their children’s evaluation in several dimensions (physical, social, school). In control group, scores between self-reported and parents reported QoL were identical. Teenagers had higher QoL scores than younger children. Cardiopulmonary exercise test is well correlated to HRQoL, especially for well-being dimension.

**Conclusion.**— QoL among children with CHD is close to that of same age healthy children except for physical well-being. HRQoL for low severity CHD patients is similar to controls. QoL for severe CHD is the most impacted. Further studies should evaluate QoL evolution in time per patient.

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