Appendix A


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29 Grown-up congenital heart disease: Continuum of care between pediatric and adults cardiologists in Reims University Hospital
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Background Congenital heart disease (CHD) are seldom cured and the increasing grown-up congenital heart disease (GUCH) population still needs specialized follow-up that has to be organized. In Reims University Hospital, it’s about 10 years ago that pediatric and adult cardiologists initiated a multidisciplinary clinic for follow-up of GUCH patients.

Objectives The aim of the present study is to describe the GUCH population followed in our hospital (CHD, treatments, outcomes, complications, social issues) and the organization of their medical care.

Methods This is a retrospective and observational study including patients with CHD which were over 18 years old in September 2013 and were seen in Reims University Hospital at least once between January 2008 and September 2013.

Results Our GUCH population was 475 patients. Median age was 25.1 years old. Sex ratio was 0.82. Among CHD, univentricular hearts were 10%. Thirty-one percent of patients were taking cardiovascular medications. Cardiac surgery had been performed in 62.1%. Interventional catheterization had been undertaken in 19.6%. Regarding the outcome, main complications were arrhythmias (17%), heart failure (5%), pulmonary hypertension (4%), endocarditis (1.2%), death (1.9%). Social supervision was needed in 14.3%. Twenty-six percent of patients had a life partner and 12.4% had children. During the period study, 11.7% of patients were lost to follow-up.

Conclusions After reaching adulthood, patients with CHD need continuous follow-up because complications in GUCH patients are not uncommon. Although transition between adolescence and adulthood is supposed to be at high risk of breaking this follow-up, the present study shows that it is possible to minimize this event. We feel that an organized continuum of care between pediatric and adults cardiologists, as we settled in our hospital, could be an effective way to meet the special needs of GUCH patients.

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30 Infective endocarditis in patients with ventricular septal defect
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Summary In the context of recent change in guidelines for prophylaxis of infective endocarditis (IE), the objective of this study was to assess the features and outcomes of IE in children and adults with non-significant ventricular septal defect (VSD).

Methods A retrospective analysis of records of patients with non-significant VSD. Clinical, echocardiographic and microbiological data, and outcomes were assessed.

Results From 1980 to 2013, 57 IE occurred (1 to 4 per year), in patients aged 14.2 ± 11.3 years (med. 12.1), 29 males (51%) and 39 were < 18 years of age. VSD was membranous in all cases, isolated (39 = 68.5%) or associated with mild aortic regurgitation or pulmonary stenosis. VSD was native in 39 (68.5%) and not diagnosed before IE occurred in 4 cases (7%). The cause of infection was unknown in 36% of the cases, while 23% were from dental, 13% from cutaneous, 9% from ENT or digestive origin, and 19% occurred in the early postoperative course of patch closure, i.e. 81% of the cases occurred in native mild VSD. Streptococcus from dental origin was the most frequent causal agent (54.5%), staphylococcus was found in 35% of cases, Gram-negative bacillus in 3.5%. Hemocultures were negative in 7% of the cases. Vegetation was the most frequent echographic lesion, and located either on VSD, and/or tricuspid valve and/or RV free wall and/or pulmonary valve. Aortic valve location occurred in 8 cases. Embolic event occurred in 28 cases (49%): multiple pulmonary embolia in 21 (37%), systemic embolia in 6. Eighteen patients were operated (31.6%): early surgery in 11 (19.3%), delayed patch closure in 7. Six patients died (10.5%). Death was not related to early surgery. FU was 13.4 ± 11.2 years (med. 10.2 years).

Conclusion Infective endocarditis impairs prognosis of mild membranous VSD and dental events are the most frequent origin of infection. Preventive surveillance and management of any dental lesion are probably to be emphasized in these patients.

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31 3D transthoracic echocardiography to assess ventricular septal defect anatomy and severity
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The pathophysiology of ventricular septal defect (VSD) is determined by the size of the defect and the state of the pulmonary