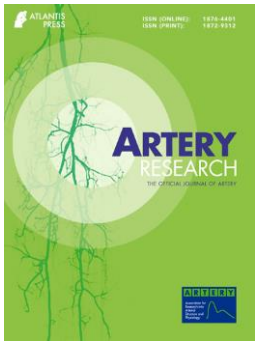

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P126: COMPARISON OF PULSE WAVE ANALYSIS ASSESSMENT METHODOLOGY IN ELDERLY MEN

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datasets of 10 patients scheduled for vascular access surgery. Datasets comprised of wall thicknesses and radii of 7 central and 11 arm arterial segments. We simulated reference models (RefModel, $n = 10$) using complete data and adapted models (AdaptModel, $n = 10$) using data of one brachial artery segment only. The remaining AdaptModel geometries were estimated using adaptation. In both models, mean brachial pressure, brachial artery distensibility, heart rate and aortic inflow were prescribed. We evaluated agreement between RefModel and AdaptModel geometries, as well as between pressure and flow waveforms of both models.

Results: Limits of agreement (bias $\pm$ 1.96SD) between AdaptModel and RefModel radii and wall thicknesses were 0.029 ± 1.3mm and $28 \pm 230\mu$m, respectively. AdaptModel pressure and flow waveform characteristics across the proximal-to-distal arterial domain were within the uncertainty bounds of the RefModel (Fig. 1).

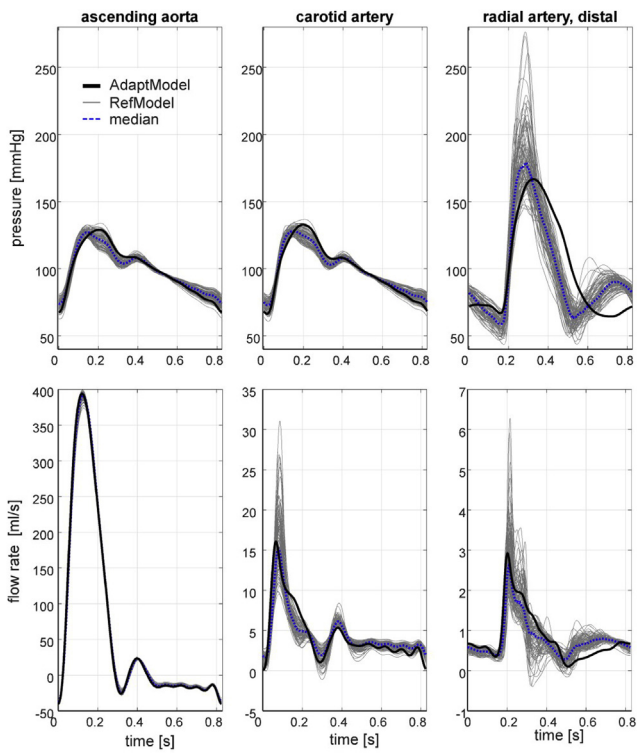

Figure 1 AdaptModel and RefModel pressure and flow waveforms at three arterial locations. For adequate comparison between the AdaptModel and the RefModel a total of 100 RefModel realisations were generated within the measurement uncertainty. The median RefModel is indicated by the blue dotted curves.

Conclusions: Our adaptation-based PWP model enables personalisation even when not all required data is available.

Reference

[1]: Kroon, W., Huberts, W., Bosboom, M., & van de Vosse, F. (2012). A numerical method of reduced complexity for simulating vascular hemodynamics using coupled 0D lumped and 1D wave propagation models. Computational and mathematical methods in medicine, 2012.

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COMPARISON OF PULSE WAVE ANALYSIS ASSESSMENT METHODOLOGY IN ELDERLY MEN

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Background: Both the Sphygmocor (S) and Vicorder (V) devices can be used for pulse wave analysis (PWA). However, large studies comparing data from both devices are lacking.

Methods: 1,722 men (78.5 ± 4.7yrs) from the British Regional Heart Study underwent PWA with S and V devices. Brachial blood pressure (BP) was assessed by V and by Omron- HEM907 (S). Measures of central Augmentation Pressure (cAP) Augmentation Index (cAIx) and central (c) BP were compared.

Results: Data were successfully obtained in 1,380 (80%) with S and 1,706 (99%) with V. 1,373 men had both S and V data. cAP and cAIx were higher in S than V (17 ± 9 vs 13 ± 5 mmHg and 29 ± 10 vs 21 ± 6% respectively, both $p < 0.001$), and were significantly correlated (cAP $r = 0.65$ cAIx $r = 0.48$ $p < 0.001$), but with greater differences at higher values. Brachial BP readings were greater with V vs Omron (mean difference $1.1 \pm 9.7/3.7 \pm 6.3$ mmHg). Mean cBP was higher in V than S (139 ± 17 vs 131 ± 19 mmHg) and despite strong correlation between measures (0.87 $p < 0.001$), cBP was more likely to be greater with S than V cBP at higher cBPs.

These differences between V + S remained directionally consistent even after adjustment for risk factors (with multiple regression analysis) and when S PWA results were recalculated using V BP in a subsample ($n = 58$).

Conclusion: PWA evaluations were more frequently successful with using V than S in elderly men. Differences in cAP, cAIx and cBP found between devices were not due to differences in BP calibration values. Further research is needed to understand the causes and clinical implications of these differences

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FLOW DYNAMICS AND ITS RELATION TO BICUSPID AORTOPATHY ASSESSED BY 4D FLOW CMR

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Purpose: Different altered flow dynamics may influence ascending aorta (AAo) dilation morphotypes in bicuspid aortic valve (BAV) (1). Using 4D-flow CMR, we aimed to identify flow variables related to root or ascending dilation in BAV.

Methods: One-hundred and one BAV patients (no severe valvular disease, aortic diameters <45 mm) underwent 4D-flow on GE 1.5 T Signa scanner (GE Healthcare, Waukesha, USA). Peak velocity, jet angle, normalized flow displacement, in-plane rotational flow (IRF), systolic flow reversal ratio (SFRR) and wall shear stress (WSS) were evaluated at proximal, mid and distal AAo. Dilation morphotypes were classified as non-dilated, ascending and root (2), using z-score > 2. Univariate and multivariate linear regression were used to identify factors related to dilation. ROC curves were performed to assess the relationship between variables obtained in the multivariate analysis and dilation morphotypes.

Results: Fusion phenotype was right-left (RL) in 78 patients, and right-non coronary (RN) in 23. Dilation morphotype was non-dilated in 24 patients, root in 11 and ascending in 66. On univariate analysis, BAV phenotype (RN), displacement and circumferential WSS presented the highest odds ratios (Table). On multivariate analysis, sex (male), proximal velocity and axial WSS were related to root morphotype (AUC 0.91, $P < 0.001$), while RN-BAV, distal IRF, and mid-AAo SFRR and circumferential WSS were related to ascending morphotype (AUC 0.81, $P < 0.001$) (Table and Figure).

Table. Univariate and multivariate factors related to of aortic dilation and dilation morphotypes.

		Univariate analysis of aortic dilation		Multivariate analysis of aortic dilation			
				Root morphotype		Ascending morphotype	
		Odds Ratio	P-value	Odds Ratio	P-value	Odds Ratio	P-value
	BAV phenotype (RL/RN)	3.23	0.02			1.33	0.008
	Sex (Male)	1.10	0.02	4.67	0.005		
Prox	Peak velocity	1.02	0.028	1.10	0.043		
	Jet angle	1.05	0.037				
	Displacement	3.56	0.001	1.11	0.021		
	IRF	1.01	0.002				
	WSS_{axial}	1.20	0.003	7.64	0.008		
	$WSS_{Cireumf}$	1.65	0.05				
Mid	Jet angle	1.07	0.006				

(*continued on next page*)