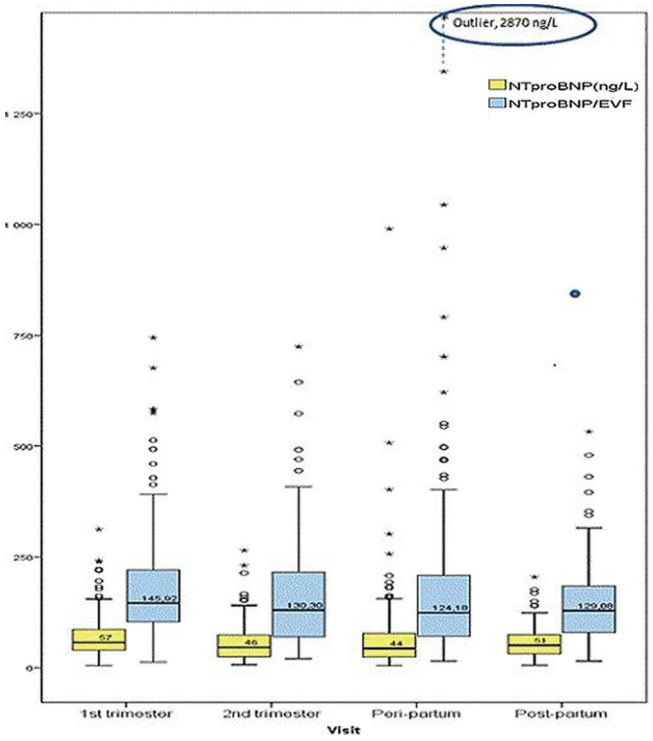
BNP values (NTpro-BNP/EVF) were during the 1st trimester 19% higher, during the 2nd trimester 9% and peri-partum 40% higher than post-partum levels. Troponin T levels were above our institutions cut off values of 14 ng/L in 2.5% of peri-partum and in 0.9% in post-partum measurements. The four patients with TNT above the upper limit were asymptomatic.



NTpro-BNP during and after pregnancy

Conclusion: NTpro-BNP levels are increased during pregnancy and peri-partum period compared to post-partum, especially when adjusted for hematocrit, but can still be used to discriminate against heart failure during pregnancy. Troponin T cut-off value of >14 ng/L were found in 2.5% of healthy pregnant women.
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P3468
What we learned from the analysis of first 301 patients from the Turkish Peripartum Cardiomyopathy Registry?

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Background: Peripartum cardiomyopathy (PPCM) is the major cause of acute heart failure in the peripartum period. ARTEMIS-1 is a retrospective registry conducted with the aim of providing insight to the real-world management of PPCM in Turkey.
Methods: 301 patients with the diagnosis of PPCM during the last 5 years, were retrospectively enrolled from 44 centers. Participating centers provided patient information including presentation, co-morbidities, diagnosis, family history, treatment patterns, relevant laboratory values, and in-hospital and 1 year outcomes via a standard questionnaire.
Results: The mean age was 30±7 years. 6.8% were diabetic and 12.3% patients had a hypertensive disorder. Presenting symptom was dyspnea in 94%. In 73% the symptoms were initiated in postpartum period. Drug therapy initiated included mineralocorticoid receptor antagonists (52%), beta-blockers (98%) and inotropics (16%). Bromocriptine was only used in 6.4%. In-hospital mortality was 6.84%. Neonatal death rate was 4.6%. Long-term follow-up was available in 81% for 1 year. 3 patients were died during follow-up and complete recovery was afforded in 35%. Recovery was associated with left ventricular (LV) ejection fraction (EF), LV end-diastolic size, right ventricular EF, systolic pulmonary arterial pressure, age at diagnosis, CRP and haemoglobin levels, and systolic blood pressure.
Conclusion: The prevalence of PPCM might be high in Turkey. Use of bromocriptine is extremely low (6.4%). Late recovery rate is 35%. Knowledge and awareness of both the diagnosis and management should be increased among cardiologists.
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P3469
Implantable cardiac defibrillators (icd) in pregnancy. Are they safe?

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Background: Clinical impact of ICD in pregnant women has not been yet well described. Only few series in literature are available.
Objective: Describe the prognostic significance of ICD in pregnant women with cardiac disease.
Methods: Between June 2011 and November 2017, we prospectively included all consecutive pregnant women with heart disease in our centre. We analysed pregnancy and delivery characteristics in 8 women with an ICD.
Results: A total of 17 pregnancies in 8 patients with ICD already implanted were followed-up. Two pregnancies were voluntarily interrupted in first trimester, one due to positive genetic diagnosis in foetus, in case 1, and the second one because of high risk of maternal mortality, in case 6. Six first trimester miscarriages and one second trimester pregnancy loss occured. Preterm birth occurred in one patient (12.5%). Median gestational age at birth was 39,2 weeks (range 29,6-40,3). A 12.5% of new-borns were small for gestational age (birth weight <10th centile). One patient, case 4, who had left ventricular ejection fraction of 15%, developed heart failure decompensation and runs of non-sustained VT, elective caesarean after pulmonary foetus maturation was performed at 29th week. One isolated discharge occurred (case 8): an inappropriate discharge in first trimester due to lead dysfunction that required lead replacement in the second trimester, with no adverse repercussion in foetal or mother's outcomes. In this patient, ICD was implanted for secondary prevention.
Conclusion: Pregnancy in women with ICD is apparently safe for both, mother and foetus. Foetus and mother morbimortality depend more on the underlying heart disease rather than the presence of an ICD.

P3470
Elevated plasma levels of galactin-3 in women with gestational diabetes mellitus, a new surrogate for cardiovascular disease in women?

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Background: Gestational diabetes mellitus (GDM) is recognized as a risk factor for cardiovascular disease (CVD) in women, and is related to future major cardiovascular events. Galactin-3 (Gal-3), a glycoprotein secreted by activated cardiac macrophages, has a role in atherogenesis through several pathways. Increased levels of Gal-3 above 8.7ng/mL has been found to be an independent predictor of increased mortality after cardiac injury. Protein convertase subtilisin/kexin type 9 (PCSK-9), a novel target for low-density lipoprotein (LDL) cholesterol reduction, is associated with metabolic disorders in young women.

Abstract P3469 – Table 1

Patient	Under-lying cardiac disease	Secondary prevention or therapies before pregnancy	LVEF (%)	Age at ICD implant (years)	Age at first conception (years)	Number of pregnancies	ICD therapies during pregnancy	Abortion or preterm births	Treatment
1	ARVC	No	60	31	29	5 (1 interrupted)	0	4 miscarriages	None
2	BS	No	60	37	31	1	0	None	None
3	LQTS	Yes	60	23	28	1	0	None	Bisoprolol
4	CHD	No	15	27	32	1	0	Preterm (29 weeks)	Acenocoumarol
5	HCM	No	60	22	27	2	0	2nd trimester foetus loss	Bisoprolol
6	IHD	No	30	38	37	1 (interrupted)	0	None	Acetylsalicylic Acid, Bisoprolol, Enalapril, Spironolactone
7	CPVT	Yes	60	16	26	5	Yes	2 miscarriages	Labetalol
8	LQTS	Yes	60	26	33	1	0	None	Bisoprolol (Peripartum)

ARVC: Arrhythmogenic right ventricular cardiomyopathy; BS: Brugada Syndrome; HCM: Hypertrophic cardiomyopathy; LQTS: Long QT syndrome; CHD: Congenital Heart Disease; IHD: ischemic heart disease; CPVT: Catecholaminergic Polymorphic Ventricular Tachycardia; LVEF: Left Ventricular Ejection Fraction.