patients daily routines and required them to coordinate the everyday life, which was facilitated by an individualized treatment time. After the EECP course patients experienced an increased level of physical performance with less angina episodes, more satisfaction with life, happier and more optimistic. It was also experienced as important to stay physical active to maintain the therapeutic effects.

Conclusions: The importance of providing an individualized care was highlighted and the approach can improve the experience of care during EECP. To offer patients a try out EECP-session before deciding on participation had significance as it motivate patients to start the treatment as they felt more secure and prepared. A successful established nurse-patient relationship also creates trust, security as well as safe environment which contribute to the experience of EECP as pleasant.

69

Exercise in patients admitted for decompensated heart failure - cardiac rehabilitation

BRUNO Delgado,[1] ANDRE Novo[2] and BARBAR Gomes[3]

[1]Hospital Center of Porto, Cardiology, Porto, Portugal [2]Escola Superior de Saude do IPB, Bragana, Portugal [3]University of Porto, Porto, Portugal

Introduction: Heart failure (HF) is characterized by dyspnea, fatigue and edema that leads to decreased exercise tolerance, functional dependence and impairment of performance in activities of daily living (ADL). Exercise is a well stablish intervention, for patients with stable cronic HF, which leads to improvement of symptoms, promotes functional capacity and decrease exercise intolerance. Exercise its not yet tested for patients during the phase of stabilization.

Purpose: To evaluate the safety and feasibility of an aerobic exercise training program for patients admitted due to decompensated HF: the ERIC program. Methods: Patients are randomized in training group (TG) or control (CG). Data includes cardiovascular history, HF history and two functional tools: London Chest of Daily Living Activities (LCADL) and Barthel Index (BI). TG patients perform the ERIC program twice a day, 6 days a week. ERIC program is a supervised aerobic exercise program, with increasing levels of intensity, divided into 5 stages: respiratory raining, gait training and climbing stairs, for progressive duration periods. In all sessions are valuated vital signs before and after the exercise, as well as Borg Modified Perceived Exertion scale. CG patients are supervised too and perform freely physical activity. At discharge, all patients perform a 6 minute walking test (6MWT), and evaluation of LCADL scale and BI.

Results: Until now, 47 patients are randomized (24 in TG - 275 sessions) with an average age of 71 (11) years old. 31 are male, 80% are in NHYA class III and 20% are class IV. At admission both groups (training vs control) of patients have the same level of functional dependence. At discharge, TG present lower LCADL and Borg score and higher BI score. Those differences are statistically significant (p=0,038 LCADL; p=0,024 Barthel). The average distance on 6MWT by TG is 72 meters higher, which is a statistically significant (p=0,031). No adverse events had occurred, like precordial pain, falls or worsening of clinical state.

Conclusions: ERIC program can safely lead patients to a better functional capacity state.

On Behalf Of: ERIC.

Table 1. Comparison of group parameters

Parameter	TG	CG
Initial BI	73	74
Final BI	96	92
Initial LCADL	36	34
Final LCADL	13	18
Borg average	3,0	3,9
6 MWT	345	273

TG - training groupCG - control group

70

Very elderly patients: good face for bad play

GR Amoroso,[1] A Bassignana,[1] M De Benedictis,[1] D Pancaldo,[1] S Dogliani,[1] A Coppolino,[1] G Bricco,[1] L Valeri,[1] L Correndo,[1] A Magliarditi,[1] A Battisti,[1] E Cavallero,[1] C Iacovino,[1] G Alagna[1] and B Doronzo[1]

[1]SS. Annunziata Hospital, Cardiology, Savigliano, Italy

Few data exist about acute cardiac syndrome (ACS) management in Very Elderly (VE) patients. Their theoretical higher risk of events supports their high fragility and it remains the main feature of the problem. We analysed 130 ACS in VE from 2014 to 2016: 47 (36%) STEMI and 83 (64%) UA/NSTEMI; two populations were similar for basal characteristics. In STEMI patients, a low part of them (25%) primary PTCA was performed, according to guidelines while in the remaining part of VE STEMI population existing co-morbidities or theoretical higher risk of events were considered prohibitive for angiography indication (75%). In VE STEMI patients, adjusting data for renal failure, diabetes mellitus condition, mental status and good general prognosis, we observed lower major events, better survival time and better performance status in VE STEMI underwent to I PTCA referring to VE STEMI patients for which I PTCA was not considered (p=0,59). Our data confirm that ACS management for VE patient depends on scrupulous initial risk/benefits ratio and, above all, it is extremely time dependent and it requires careful management of co-morbidities. Smallness of the sample needs to have more extensive studies on the topic.