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Methods: Multicentre, multinational registry in patients undergoing TAVI. Co-primary objectives are to establish predictive value of CGA (Multidimensional-Prognostic-Index [MPI], short-physical-performance-battery [SPPB], SilverCode) for mortality and/or hospitalization and to demonstrate changes in the CGA after TAVI.
Results: A total of 72 patients with a mean age of 85.4 ± 2.9 years and a EuroScore II of 9.7 ± 8.3% were enrolled. Three months after TAVI 94.8% were classed NYHA I/II (18.8% at baseline; $p < 0.001$), the MPI was 0.29 ± 0.12, SPPB 7.6 ± 2.9 ($p < 0.001$), and SilverCode 21.1 ± 7.9 (vs. 0.32 ± 0.10, 5.6 ± 3.3 and 22.0 ± 7.3 at baseline). Eight patients reached the combined endpoint of death/stroke within 3 months. These patients had a higher MPI and a lower SPPB at baseline, compared to those without (MPI: 0.103 [95%CI, 0.031 to 0.176; p=0.006]; SPPB: −3.962 [95%CI, −6.228 to −1.696%; $p = 0.001$]). In the multivariate analysis, a high SPPB at baseline was associated with a reduced risk for stroke and/or death within 3 months after TAVI.
Conclusion: The results suggest that it might by beneficial to include CGA into the pre-TAVI assessment to improve outcomes. Lower SPPB performance appears to best predict poor outcomes within 3 months after TAVI.

O-054
Outpatient comprehensive geriatric assessment: effects on frailty

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Objectives: The prevention and treatment of frailty is a great challenge to health care in the future. Elderly receiving Comprehensive Geriatric Assessment (CGA) as hospital inpatients have decreased institutionalization and mortality. This study aimed to analyze the effects of outpatient CGA on frailty in community dwelling elderly people with multimorbidity.
Methods: The Ambulatory Geriatric Assessment – Frailty Intervention Trial (AGe-FIT) was a randomized controlled trial with an intervention group (n = 208) and a control group (n = 174). Frailty was one of the secondary outcomes. Participants were community dwelling elderly people with multimorbidity (N = 382). Inclusion criteria were: age ≥75 years, ≥3 diagnoses per ICD-10, and ≥3 inpatient admissions during 12 months prior to study inclusion. The intervention group received CGA-based care in an Ambulatory Geriatric Unit by a multidisciplinary team. The control group received usual care. Frailty was classified with the criteria from the Cardiovascular Health Study (CHS) at baseline and at 24 months.
Results: After 24 months, there was a significant difference in proportion of patients classified as pre-frail between the intervention group and control group, $p = 0.029$. The mortality was high, 18.8% (n = 39) in the intervention group and 27% (n = 47) in the control group. This was expected considering the high risk of mortality related to old age, multimorbidity and frailty.
Conclusion: These results suggest that outpatient CGA and subsequent interventions could have an important role in delaying development of frailty.

O-055
Multidimensional prognostic index in hospitalized elderly patients across Europe and Australia: a prospective multicenter study of the European MPI_AGE project

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Background: The Mutidimensional Prognostic Index_Age (MPI_AGE) is a multicenter project funded by the EU in the frame of the European Innovation Partnership on Active and Healthy Ageing, Second Health Programme (2008–2013) with the aim to implement the use of MPIs to improve cost-effectiveness of interventions in multimorbid frail older persons.
Objective: The objective of this study (Work Package 6) was to improve resource allocation in hospitalized older patients by using the MPI, a validated predictive tool for mortality based on the Comprehensive Geriatric Assessment (CGA).
Methods: 1,017 individuals aged 65 years and over admitted to nine acute Geriatrics Units in Italy, France, Germany, Spain, Czech Republic, The Netherlands and Australia were included in the study. In all patients clinical and multidimensional information, including the CGA-based MPI, were collected on admission and on discharge.
Results: On admission all patients (mean age 84.7 ± 7.6 years and prevalently females, 60.3% vs. 39.7%, $p = 0.0001$) were classified according to the MPI score. The median MPI score improved significantly from admission to discharge 0.63 vs 0.56, paired t test = 0.004, respectively. Overall, the MPI score on discharge improved in 35.25% of patients (mean age 83.81 ± 7.76 years), did not change in 38.13% of patients (mean age 84.43 ± 7.55 years) and worsened in 26.62% patients (mean age 86.20 ± 7.28 years), p for trend <0.001. No significant differences were observed between men and women in terms of improvement and worsening (Pearson Chi squared test, $p = 0.14$).
Conclusions: During hospitalization MPI score changes in most of patients; these changes are age-related.

O-056
Dysphagia among the community dwelling elderly people: how often? How we aware?

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Aim: Dysphagia is described a geriartric syndrome that occurs more frequently with aging. This clinical problem is associated with deterioration in functionality, malnutrition, infections, increase in mortality and usually ignored. The prevalence of dysphagia in the elderly among have been reported dysphagia is described a geriartric syndrome that occurs more frequently with aging. This clinical problem is associated with deterioration in functionality, malnutrition, infections, increase in mortality and usually ignored. The prevalence of dysphagia among elderly in many different populations have been reported between 13,8% and 23,4%. In our country, a study investigating the incidence of dysphagia have not been reported. In this study, our aim is screening the prevalance of dysphagia among elderly living in the community in our country.
Materials and methods: The study includes patients admitted to our clinic between July 2015 and March 2016, the patients ages were between 60 and 98 years old and they were prospectively and consecutively included in study. Dysphagia screening was done by scanning the EAT-10 questionnaire. 2 separate threshold for EAT-10 score of dysphagia, threshold (3 or 15) was used. The patients' age, gender, total disease, the total number of drug were noted. Dysphagia awareness was investigated in patients with detected dysphagia. For this purpose, dysphagia complaints, the patients were asked if they would express dysphagia complaints when there is no screening questionnaire.

Results: The study included 959 elderly patients (272 male, 687 female). Mean age was 74.21 ± 7.4 years. The total number of diseases, the total number of drugs; EAT-10 total score and distribution by and gender are shown in Table 1. In the study population EAT-10 threshold 3 and threshold 15 detected by positive dysphagia screening by prevalence and gender distribution are summarized in Table 2. Patiens with EAT-10 score ≥3 said symptoms without prompting symptoms of dysphagia with a percentage of 32.7%, while this percentage for patients with EAT-10 score >15 was 51.5 (Table 2). In EAT-10 questionnaire, the article which has the highest positivity and the highest score was the item questioning dysphagia with liquids that "I am making extra effort to swallow liquids" (Table 3). Factors independently associated with advanced age and EAT-10 score in linear regression analysis was established as advanced age (p = 0.007), female gender (p < 0.001) and the high number of drugs (p < 0.001).
Conclusions: In our study, screening the elderly outpatient prevalence of dysphagia; it was found with a significant incidence (64.8%) of dysphagia with threshold EAT-10 score ≥3; when it was 7.1 for thresholds EAT 10 > 15. Dysphagia in the elderly living in the community is a common problem in our country. Close to half of patients with significant dysphagia does not express dysphagia without query. Female sex and drugs excess number are risk factors for dysphagia. Our results suggest the need for performing dysphagia screening in the elderly.

O-057
Prognostic value of estimated glomerular filtration rate in older patients admitted in an internal medicine ward at 6 and 12 months follow-up

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Introduction: Kidney physiological ageing usually results in a decline of glomerular filtration. Chronic kidney disease is associated with increased morbi-mortality of older patients. Our aim was to analyze outcomes at 6 and 12 months (6 M and 12 M) of a cohort of patients ≥75 years admitted in an Internal Medicine Ward according estimated glomerular filtration rate (eGFR).
Methods: Prospective longitudinal cohort study of 100 patients. Comprehensive geriatric assessment at baseline. Body composition assessed by bioimpedance. eGFR calculated by Cockcroft-Gault equation (CGeq). Survival and hospital readmission at 6 and 12 M assessed by phone contact and hospital record analysis.
Results: One patient lost during follow-up. Average age 83.7 years, 63% males, average Cumulative Illness Rating Scale Geriatrics 11.2, average baseline Barthel score 63.6, 70% malnourished. Cumulative mortality: 6 M 48.4%, 12 M 53.5%. Average eGFR 57.8 ± 58.3 mL/min/1.73 m^2. Lower eGFR was statistically significantly associated with emergency department admission at 6 M (p 0.008) and 12 M (p 0.011) and rehospitalisation at 12 M (p 0.042). Lower serum creatinine was associated to lower Free-Fat Mass (FFM) according Deurenberg equation (p 0.001). Consequently, lower FFM was associated with higher eGFR (p < 0.001). This "higher eGFR" should be carefully understood as it results from reduced muscle mass and not from preservation of kidney excretory function. Association between eGFR calculated by CGeq and mortality was not detected.
Conclusion: CGeq results strongly depend on FFM and therefore might not be accurate to estimate kidney function in sarcopenic older people. Nevertheless, decline in kidney function seems to be related to increased hospital readmission.

O-058
Indications, safety, and diagnostic efficacy of balloon-assisted enteroscopy in the elderly: a systematic review and meta-analysis

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Background: Balloon-assisted enteroscopy (BE) are commonly used for investigation of small bowel diseases. Currently, there are limited data on the safety and efficacy of BE in the elderly. Therefore, we performed meta-analysis to assess the safety and diagnostic efficacy of balloon-assisted enteroscopy in the elderly compared to those in the younger.
Methods: We searched PubMed, Medline, Elsevier ScienceDirect and EMBASE databases until May, 2016, for articles assessing the safety and efficacy of balloon-assisted enteroscopy in the elderly. Data were extracted and assessed to evaluate the pooled complication rate and diagnostic yield of BE in the elderly compared to those in the younger patients.
Results: Seven articles involving 1,161 patients (1490 procedures) were included. The elderly were with high co-morbidity rate (74.7%). Obscure gastrointestinal bleeding was the most common indication (87.7%), and angioectasia was the most frequently final detected abnormality (40.1%). The pooled diagnostic yield of BE in the elderly group was 0.67(95% CI: 0.56, 0.77). The pooled relative diagnostic yield of BE in the elderly group compared to the younger group was 1.51 (95% CI: 1.14, 2.00; P = 0.004). The pooled complication rate of BE in the elderly group was 0.03(95% CI: 0.01, 0.04). The pooled relative complication rate of BE in the elderly group compared to the younger group was 0.88 (95% CI: 0.33, 2.32; P = 0.79).
Conclusion: Our study demonstrates that the complication rate is not higher in the elderly compared to the younger, and the elderly are more likely to a have higher diagnostic yield than that in the younger.

O-059
The psychosocial status of community dwelling elderly (65–75 years)

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Introduction: Aging increases the chance of frailty [1]. Frailty can be understood as the loss of functioning and independence [2]. The Groningen Frailty Indicator (GFI) is valid measurement instrument to asses frailty [3,4]. The GFI has 8 domains; mobility, wellbeing, vision, hearing, weight, comorbidity, cognition and psychosocial functioning. The aim of this study is to provide an overview of the psychosocial status of community dwelling elderly (65–75 years).
Methods: As part of the PERSSILAA-project (FP7-ICT-610359), elderly (65–75 years) were asked to complete various assessment instruments, including the GFI. The GFI consists of 15 items. The maximal score on the GFI is 15 and a score above 4 can be seen as frail [3].
Results: At this moment, 3,199 elderly (48% male and average age 70.0 SD 4.0 years) participated and completed the GFI. The mean score on the GFI was 2.2 (SD 2.3) and 24.7% of the elderly were categorized as frail. Considering the frail elderly, 72.9% experienced emptiness, 76.3% missed people around them, 53.7% felt abandoned, 74.3% felt sad or depressed and 54.6% felt nervous or anxious. Of the frail elderly, 96.1% suffered from at least one of these problems, 74.1% suffered from at least 3 of these problems and 17.5% suffered from all of these problems.
Key conclusions: Compared to the other domains of the GFI, psychosocial functioning plays an important role in frailty. Therefore, the role of psychosocial functioning should not be underestimated and intervention to prevent frailty should focus on improving the psychosocial status of elderly.