

to decrease the progression of chronic kidney disease (CKD) to ESRD. Specific diets are assigned according to the patient's CKD stage and patients are given individualized consultations with a dietitian. Analyzing the effectiveness of this program can lead to further funding and patient recruitment.

We hypothesize that the experimental cohort of stage 3b CKD patients in the program will have a slower rate of eGFR decline compared to a control cohort of stage 3b CKD patients.

**Methods:** This is a retrospective cohort study on stage 3b CKD patients who have completed CKDEP. Stage 3b CKD, defined as an eGFR of 30–44 (mL/min/1.73 m<sup>2</sup>), was selected for analysis due to the higher likelihood of progressing to ESRD compared to other stages. For both study groups, the rate of change in eGFR over time was measured by calculating the slope of eGFR for each patient, with time elapsed (in days) as the x-axis and eGFR measurements as the y-axis. A Student's t-test was performed to analyze significant differences in eGFR rate of change.

**Findings:** There was no statistically significant difference (p-value = 0.27) between the experimental (n=91) and control cohorts' (n=75) rates of change in eGFR. The experimental cohort's average initial eGFR was 37.1 +/- 4.4 and the average final eGFR was 38.0 +/- 9.6. The control cohort's average initial eGFR was 38.2 +/- 9.2 and the average final eGFR was 39.2 +/- 13.7. The average rate of change in eGFR for the experimental was 0.0065 +/- 0.0437 and for the control was -0.0179 +/- 0.1811.

**Interpretation:** Although our analysis does not show a statistically significant difference, there was a positive average rate of change in eGFR for the experimental cohort compared to a negative average rate of change in eGFR for the control cohort. This suggests that Taipei Hospital's CKDEP may have a beneficial impact in slowing the progression of CKD. Future studies include stratification and analysis of patients based on comorbidities, age, and gender.

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### Mortality from Thermal Burns in Patients Using Emergency Medical Services in India: A Prospective Study

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**Background:** Globally, there were over 33.5 million thermal burn injuries in 2013, resulting in over one million years lost to disability, and approximately 237,500 deaths. The majority of burn deaths, an estimated 90%, occur in low- and middle-income countries (LMICs) with India alone accounting for 163,000 fire-related deaths annually. The goal of our study was to characterize the demographics, management, and outcomes of patients using emergency medical services (EMS) for thermal burns in India.

**Methods:** We conducted a prospective observational study of patients using emergency medical services (EMS) for thermal burns across five Indian states over four months in 2015. Any patient calling a toll-free, state-wide, centralized EMS system for a burn injury was eligible for inclusion. Exclusion criteria included calls for burns caused primarily by chemicals or electricity, interfacility transfers, patients who were absent upon ambulance arrival, and patients who refused care and transport. Follow-up phone calls were completed at 2, 7, and 30 days. Our primary outcome was mortality. Secondary outcomes included prehospital care and functional status. Multivariate regression was performed to identify predictors of mortality.

**Findings:** We enrolled 439 patients, 30-day follow-up rate 85.9%. The median age was 31 years; 50.3% (N = 221) lived in poverty; and 65.6% (N = 288) were women. EMS transported most patients within two hours (94.3%; N = 395). Overall 30-day mortality was 64.5%, but was 90.2% in women with self-inflicted burns. In total, 45.6% (N = 200) reported self-inflicted burns. Intentional burns involved a median total body surface area of 80%, versus 35% in accidental burns. Inhalation injury (OR 6.7), intentionality (OR 6.6), economic status (OR 2.6), and gender (OR 2.3) predicted mortality by multivariate regression.

**Interpretation:** EMS connects critically burned patients to needed care in India. Mortality from thermal burns remains exceedingly high, with women disproportionality suffering self-inflicted burns and higher mortality. It is critical that public health officials recognize that burn prevention in India requires integration with mental health and gender-based violence supportive services.

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