Results Following the implementation of the direct entry pathway in May 2010 the CTBT for all patients admitted direct to our hospital have reduced. This is statistically significant when looking at Quarter 2 results from baseline. Patient safety has not been compromised. Patients who were admitted directly have been asked about their experience and if anything could be done differently from their perspective. They have said:

- The process is quick which is good from their perspective
- They are fully informed
- The ambulance crews deal with them competently
- The lab staff are waiting for their arrival.

Conclusions The CCU nurses have embraced this development and expansion of their nursing practice, allowing major changes to be made to the Primary Angioplasty pathway within the existing infrastructure, despite the challenges of working within the complex nature of traditional geographical referral patterns. Along with the work of all members of the multi disciplinary team this has significantly reduced times to treatment for patients.

77 SCREENING FIRST DEGREE RELATIVES FOR HYPERTROPHIC CARDIOMYOPATHY: 12-MONTH EXPERIENCE OF A CARDIO-GENETICS NURSE SERVICE

doi:10.1136/heartjnl-2011-300198.77

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Introduction Hypertrophic cardiomyopathy (HCM) is an autosomally transmitted cardiomyopathy with an estimated gene prevalence of 1:500, and an important cause of sudden cardiac death. Screening to identify at risk first degree relatives is therefore recommended. The British Heart Foundation (BHF) recently funded nine Nationwide cardio-genetic nurses to support local initiatives. Our application for a nurse was successful and we present our 12-month experience of HCM screening.

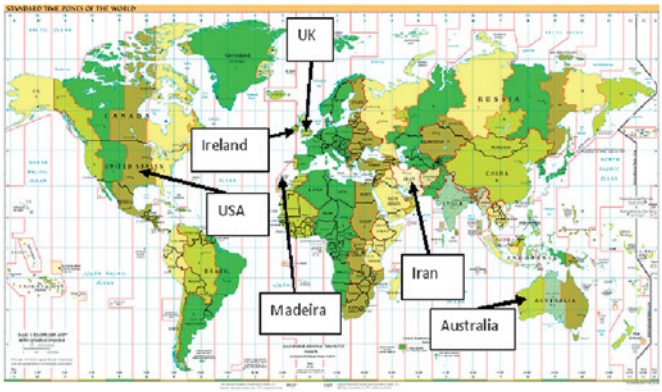
Methods We mapped the course of patients with suspected HCM referred to our tertiary heart muscle clinic which serves a population of 1.4million. Following phenotype confirmation, a family tree and contact details from the index case were recorded by the cardio-genetic nurse. The index case was given literature to pass onto at risk relatives. The information pack included an open invitation (referral via primary care) to attend for screening. For relatives residing outside our catchment area screening was arranged via links with the BHF cardio-genetic network and other health care providers. Relatives domiciled outside UK were given our details with offers to support screening. Throughout, strict adherence to patient confidentiality was maintained.

Results Over 12 months, 64 index HCM cases presented to our heart muscle clinic. Pedigree analysis identified 221 first degree relatives at risk of carrying the HCM gene; mean index-to-at RR: 1-to-3.4 (range 0–14 subjects). Of the 221 at risk subjects, 71 (19 through paediatrics) have undergone screening through clinical assessment at our unit with plans for long-term 2–5 yearly follow-up in view of variable gene penetrance. Of the 71 screened subjects, 15 were newly diagnosed with HCM. Newly diagnosed HCM patients underwent further risk stratification for sudden cardiac death; where we identified 3 patients at high risk (≥2 conventional high sudden death risk factors). After appropriate counselling, these 3 patients have received primary prevention defibrillators. Despite our approach, 52 subjects remain unscreened (Abstract 77 table 1), either due to complex family relationships (n=14), personal preference (n=28) and/or geographical/logistical reasons (n=10).

Abstract 77 Table 1 Screening outcomes of 221 at risk subjects identified from 64 index cases of hypertrophic cardiomyopathy

	Number of Patients
New screening initiated (local heart muscle clinic)	52
New screening initiated (local paediatric clinic)	19
New screening initiated (out of area service)	6
Pre-existing screening in place	63
Personal preference (declined screening)	28
Awaiting response from subject (literature delivered)	19
Complex family relationships (unable to deliver literature)	14
Geographical/Logistical constraints	10
Subject deceased (non-hypertrophic cardiomyopathy)	3
Subject deceased (hypertrophic cardiomyopathy)	7

Conclusions Proactive screening for HCM can be effectively facilitated by cardio-genetic nurse services. Each new index case generates 3–4 at risk relatives who require long-term surveillance. Of 71 asymptomatic at risk subjects screened in our unit, we diagnosed 15 new cases of HCM, and 3 patients at high risk of sudden cardiac death who subsequently received primary prevention defibrillator implantation.



Abstract 77 Figure 1

78 FIRST YEAR EXPERIENCE OF A DEDICATED "RADIAL LOUNGE" FOR PATIENTS UNDERGOING ELECTIVE PERCUTANEOUS CORONARY PROCEDURES

doi:10.1136/heartjnl-2011-300198.78

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Introduction The potential to achieve safe early mobilisation and same day discharge on a consistent basis after radial artery access has provided us with the opportunity to make a step change in the way we deliver elective care to patients undergoing percutaneous coronary procedures. We designed a dedicated "radial lounge" to accommodate patients before and after their procedure with the aim of minimising the feeling of "hospitalisation" that accompanies most encounters with health services. The lounge is a day case unit that has no beds, only chairs, and televisions but no cardiac monitors. Patients remain in their clothes throughout their hospital visit. Here we report our first year's experience of this facility. Methods: The study population comprised all patients who attended the radial lounge between July 2009–June 2010 for coronary angiography or percutaneous coronary intervention (PCI). Patients were suitable for the radial lounge if they were elective cases who had a satisfactory radial pulse and no pre-procedure contraindication to