AF that is measurable, fits within the current NHS landscape and maximises clinicians and managers time effectively. We have educated over 100 clinicians in the use of the pathway to date.

We anticipate the this pathway will increase the detection of AF, increase in the number of people with AF treated with effective and appropriate AC, reduce the number of people with AF related stroke and increase support to clinicians, providers and commissioning organisations.

We are currently evaluating this pathway over a 24 month period at both general practice and network level using GRASP-AF, CHA_2DS_2-VASc and other KPIs within the pathway. We anticipate that this pathway will benefit all professional stakeholders involved in AF care but more importantly, improve outcomes for people with AF.

51 IMPACT OF THE INTRODUCTION OF A STANDARDISED ICD PROGRAMMING PROTOCOL: REAL-WORLD DATA FROM A SINGLE CENTRE

Nicholas Sunderland*, Amit Kaura, Anthony Li, Ravi Kamdar, Ed Petzer, Para Dhillon, Francis Murgatroyd, Paul Scott. *King's College Hospital*; **Presenting Author*

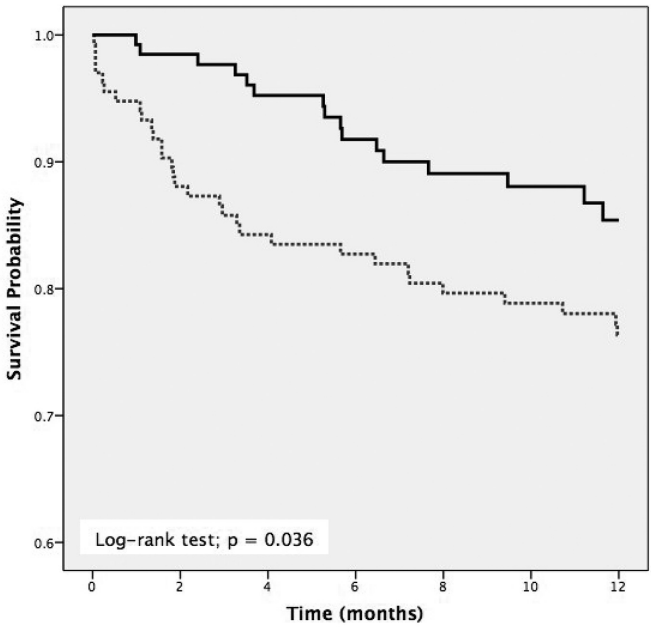
10.1136/heartjnl-2016-309890.51

Aims Randomised trials have shown that empiric ICD programming, using long detection times and high detection zones, reduces device therapy in ICD recipients. However, there is less data on its effectiveness in a "real-world" setting, especially secondary prevention patients. Our aim was to evaluate the introduction of a standardised programming protocol in a "real-world" setting of unselected ICD recipients.

Methods We analysed 270 consecutive ICD recipients implanted in a single centre – 135 implanted prior to protocol implementation (Physician-Led group) and 135 after (Standardised group). The protocol included long arrhythmia detection times (30/40 or equivalent) and high rate detection zones (primary prevention lower treatment zone 200 bpm). Programming in the Physician-Led group was at the discretion of the implanter. The primary endpoint was time-to-any therapy (ATP or shocks). Secondary endpoints were time-to-inappropriate therapy and time-to-appropriate therapy. The safety endpoints were syncopal episodes, hospital admissions, and death.

Results At 12 months follow-up, 47 patients had received any ICD therapy (Physician-Led group, n = 31 vs. Standardised group, n = 16). There was a 47% risk reduction in any device therapy (p = 0.04) and an 86% risk reduction in inappropriate therapy (p = 0.009) in the Standardised compared to the Physician-led group. Results were consistent across primary and secondary prevention patients. There were no significant differences in the rates of syncope, hospitalization and death.

Conclusions In unselected patients in a "real-world" setting introduction of a standardised programming protocol, using long detection times and high detection zones, significantly reduces the burden of ICD therapy without an increase in adverse outcomes.



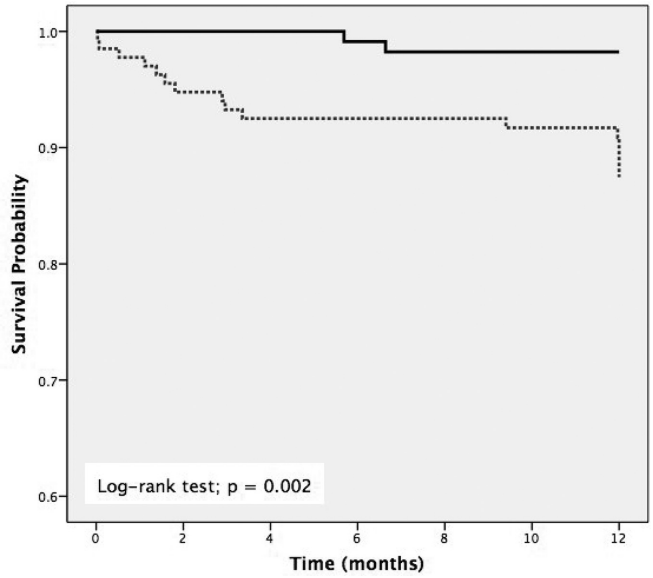
Abstract 51 Figure 1 Kaplan-Meier curves for survival from any-therapy. Physician-Led (dotted) vs. Standardised (black)

52 IMMEDIATE MANAGEMENT FOLLOWING CARDIAC IMPLANTABLE ELECTRONIC DEVICE PROCEDURES; WIDE VARIATION IN PRACTICE FROM A UK SURVEY

Robert Bowers*, Alison Parish, Richard Balasubramaniam, John Paisey, Mark Sopher. *[1]Royal Bournemouth Hospital*; **Presenting Author*

10.1136/heartjnl-2016-309890.52

Introduction Following the implantation of a CIED a number of checks are made to document device function and exclude procedure complications. Traditionally these have been performed the day after the procedure, mandating an overnight admission. Recently, both the need for these investigations and



Abstract 51 Figure 2 Kaplan-Meier curves for survival from inappropriate therapy. Physician-led (dotted) vs. Standardised (black)

their timings have been questioned, especially in the context of same day discharge practices.

Methods Staff at the largest volume device implant centres in the UK as well as to a selection of other implant centres chosen on an ad hoc basis were surveyed. Responses were received from 31 centres. The aim of the study was to assess the range of post implant practice currently used in the UK relating to device procedures where a new lead was introduced.

Results A range of practices were described relating to the timing and use of both CXR and device checks. 35.5% of centres did not mandate a post procedure CXR. At these centres, the most common reasons for requiring a CXR were the type of access used and the suspicion of procedure complication.

Use of device checks once a patient had left theatre also varied. Most centres performed a full interrogation, however 4 used only a 12 lead ECG, one a magnet check and one required no further check other than that performed on the table at the end of the case.

Timings for the CXR and check were similar within a centre but differed significantly between centres. 65% of centres responded to indicate that both investigations could be performed after a wait of 4 h or less from the time of implant.

Same day discharge following bradycardia device implant was considered at 68% of centres and 55% of centres following ICD/CRT device procedures. A number of factors were said to be used to guide its suitability.

Routine echo optimisation of all CRT devices was only reported by 16% of centres.

Conclusion There is a broad range of different practice between UK centres, relating to both the timing and use of CXR and device checks. Although still carried out in a large number of centres, traditional next day checks are no longer the norm.

53 TIMING OF CARDIAC RHYTHM MANAGEMENT DEVICE COMPLICATIONS: IS DAY CASE IMPLANTATION SAFE?

[1]Katharine Nelson*, [2]Sarah Welsh, [1]Jonathon Batty, [1]Stephen Lord. *[1]Freeman Hospital; [2]Newcastle University; *Presenting Author*

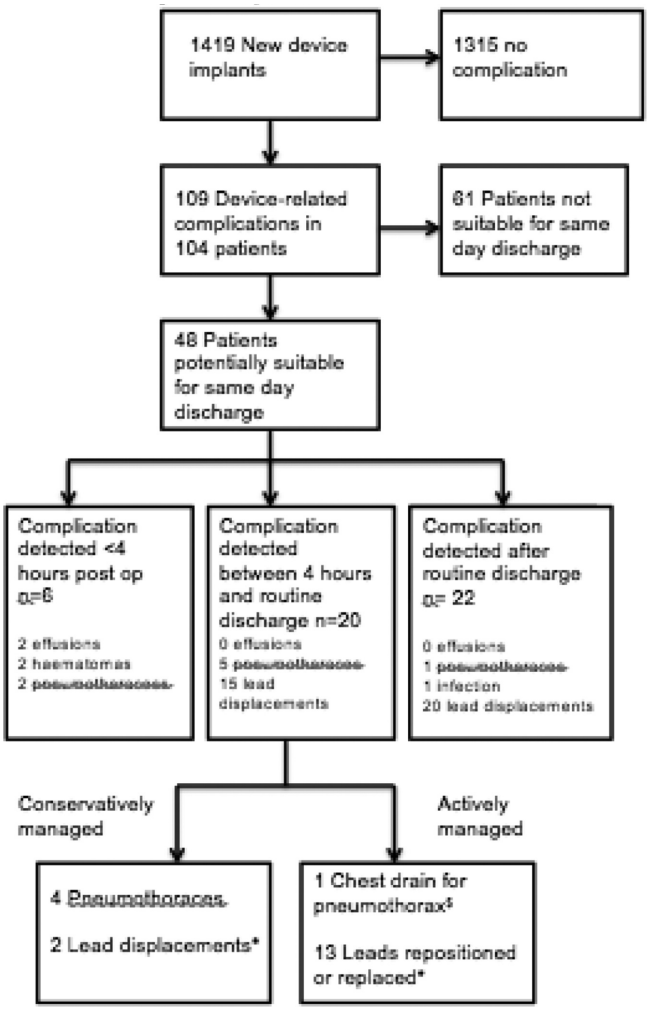
10.1136/heartjnl-2016-309890.53

Introduction Cardiac rhythm management (CRM) device implantation is a common medical procedure, considered to be safe in the majority of patients. Potential complications include pneumothorax, lead displacement, haematoma, infection and other wound problems. Whilst traditionally involving an overnight stay, some centres offer day-case procedures to selected patients. We sought to determine the time from implantation to detection of device-related complications, and thereby infer the safety of day-case implantation.

Methods A prospective database of all patients receiving a new CRM device, system replacement or upgrade over a 1 year period was maintained and screened for complications. Where identified, all medical, nursing and pacing notes were reviewed in order to determine first possible identification of a device-related complication; by symptoms, nursing observations or clinical investigations. Complications presenting less than 4 h post procedure were assumed to have prevented potential same day discharge. Pneumothoraces, pericardial effusions and wound problems were considered significant if they were actively managed. Lead displacements were considered significant if the patient experienced symptoms, loss of pacing function if pacing dependent, or a defibrillator discharge. Same-day discharge was considered to be non-inferior to routine discharge if no significant complication of pacing presented between 4 h and the time of routine discharge.

Results 109 complications occurred in 104 patients out of 1419 undergoing device implantation between October 2013 and September 2014. Complication rates according to device are detailed in Table 1.

61 of 104 (58.7%) patients would not have been triaged to day case implantation due to an urgent device indication and/ or scheduled upgrade or system replacement. 6 (5.5%) complications presented before 4 h and so would have prevented early discharge. 22 presented after discharge the following day, our usual standard of care. 20 complications (5 pneumothoraces, 15 lead displacements) presented between 4 h and the time of discharge. One pneumothorax was managed with a chest drain having been identified on routine chest X-ray without prior symptoms or signs. Of 15 patients with lead displacement 4 (26.7%) experienced symptoms of twitch or palpitations, the remainder being identified on routine device interrogation the following day. 13 leads were repositioned or replaced and 2 were deactivated. There were no



Abstract 53 Figure 1 Device-related complications in patients suitable for day-case implantation