Abstract 70 Table 2 Summary of projected cost data

Item	Total
Bed-days saved per patient by referring to syncope clinic (n)	4
Mean monthly frequency of patients reviewed in syncope clinic (n)	16
Total in-patient bed days saved per month (n)	64
Total in-patient bed days saved per year (n)	768
Cost of in-patient bed-day (£)	273
Cost of saved in-patient bed-days saved per year (£)	209,664

were excluded. Student's t-test and chi-squared tests were used to compare continuous and categorical data respectively.

Results The median length of admission for patients remaining in hospital for assessment was 4 days compared to 1 day for those referred to the syncope assessment unit ($p < 0.05$). The median waiting time from discharge for a syncope unit appointment was 3 days. 32% of the patients referred to the syncope clinic were reviewed or discussed with a cardiologist. This figure was higher (46%) for those patients remaining in hospital for assessment although not statistically significant ($p = 0.151$). There was no significant difference in 30-day readmission rate with syncope or 90-day mortality rate between the two ($p > 0.05$). 93 patients were reviewed in the syncope clinic over the first 6 months (16/month). With an in-patient bed-day costing £273, referral of patients to the syncope clinic at this rate would save £17,472 per month and £209,664 per year (Tables 1 and 2).

Conclusions The introduction of a novel low-risk syncope assessment unit promotes early discharge from hospital with prompt outpatient medical review and shorter waiting times for diagnostic investigations. Our data suggests this is both cost-effective and safe with improved patient care.

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Congenital Heart Disease

71 LONG-TERM OUTCOMES OF COARCTATION OF AORTA IN EAST OF ENGLAND – THE NORFOLK AND NORWICH AND PAPWORTH HOSPITAL EXPERIENCE

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10.1136/heartjnl-2016-309890.71

Background Coarctation of the aorta (CoA) is associated with premature mortality with a mean survival age of 35 year in spite of early repair. Treatment paradigms are continually changing and contemporary data on CoA are needed.

Methods The Norwich and Papworth (NORPAP) dataset was set up in 1993 to record demographics, treatments and outcomes of adult congenital heart disease (ACHD) patients in the east of England. We report on the CoA subset.

Results In total 2322 patients were included in the dataset and of these 223 had CoA (9%): 146 males and 77 females, mean age 40 years (range 16–94). Hypertension was documented in 34% and coronary heart disease 6%. 91% received a corrective procedure (80% surgical and 11% percutaneous) and of these 38% required more than one procedure. Percutaneous intervention made up about half of all re-do procedures. 13% of second procedures were not related to CoA and were mostly aortic valve replacement. There were two case of subarachnoid haemorrhage and 2 deaths (0.8%) over approximately 10 years follow up.

Conclusion There is a high initial intervention rate in CoA with about 40% requiring additional intervention. The serious complication rate was low in our cohort suggesting that prognosis is improving over time.

72 MORBIDITY AND MORTALITY ASSOCIATED WITH CONGENITAL HEART DISEASE IN ADULTS WITH TRISOMY 21 (T21)

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10.1136/heartjnl-2016-309890.72

Background Trisomy 21 is frequently associated with congenital heart disease (CHD). Survival and life expectancy has increased as a result of surgical intervention and medical therapies. The NORPAP GUCH database, started in 1993, has 2668 patients.

Methodology Patients with Trisomy 21 were selected from the NORPAP database. Population demographics, underlying diagnosis, comorbidities and mortality were analysed.

Results 110 patients had T21; Mean 34 years, Median 30 years, M:F 1.1:1 (Figure 1). Underlying CHD was AV Canal defect 57 (51.8%), VSD 30 (27.3%), Fallot Repair 10 (9.1%), Secundum ASD 6 (5.5%), Bicuspid Aortic Valve 3 (2.7%), Mitral Regurgitation 1 (0.9%), Single Ventricle 1 (0.9%), Pulmonary Stenosis 1 (0.9%), PDA 1 (0.9%). 61 (55%) patients had had surgery. Of those under 40, 51% were unoperated.

Death occurred in 9 patients (9%). Average age at death 46 years. 78% of deaths were in patients with AV Canal defect. Mode of death was cardiac in 8 and PAH-CHD was present in all but one.

Figure 2 shows associated comorbidities. 35% have PAH -– 59% receivetargeted therapy.

Conclusion AV Canal defect was the most frequent underlying CHD in the T21 NORPAP cohort and was associated with