Results Statistical significance was assessed using the Mann-Whitney U test (for non-parametric data) and the Student's T-test (for parametric data). Statistically significant differences between black and white HCM patients were noted in the% predicted peak power and% predicted peak VO_2/kg. (Table 1)

Abstract 133 Table 1

	Mean values		p-value (2-sided)
	Black HCM	White HCM	
Age (years)	45.08	45.47	0.9214*
BMI (kg/cm^2)	26.86	27.96	0.416*
Peak R achieved	1.19	1.20	0.3576**
% predicted VO_2/HR	95.77	102.42	0.177**
VE/VCO_2 slope	31.72	29.43	0.3524**
% predicted peak power (Watts)	80.92	104.89	0.0016**
Peak VO_2/kg (mls/min/kg)	25.93	27.53	0.7114**
% predicted peak VO_2/kg (mls/min/kg)	77.85	88.03	0.0434**
VO2 at lactate threshold (% of peak $V0_2$/kg)	58.88	55.66	0.3472**

Conclusion Black HCM patients achieve a significantly lower% predicted peak power on CPET (24% lower) compared with white HCM patients. Black HCM patients also demonstrate a significantly lower% predicted peak VO_2/kg (10% lower) compared to white HCM patients. Larger studies are required to corroborate these ethnic differences, however, this study suggests that the current standard cut-off of a peak VO_2>120% predicted may be too high for a black athlete resulting in a false positive diagnosis of HCM.

134 INCIDENCE OF INFECTIVE ENDOCARDITIS IN UK: A MULTICENTRE RETROSPECTIVE ANALYSIS

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Background Infective Endocarditis (IE) occurs in groups of people who are deemed high risk. Previously high-risk individuals undergoing invasive procedures were recommended prophylactic antibiotics. In 2008 NICE issued new guidance to avoid prophylactic antibiotics use.

Aim We aimed to evaluate the incidence of confirmed Infective Endocarditis in two sites across the North West region prior to and after the implementation of the 2008 guidance, including causative infective organisms, Echo findings, subsequent morbidity and mortality.

Methods OPCS-4 (Office of Population, Censuses and Surveys classification-4th Edition) system and the standard code allocated were retrospectively analysed for all admissions related to Infective Endocarditis for the years 2007–2008 and then again for the years 2012–2015.

Results The incidence of IE dramatically increased for the years after the guidance came in to effect compared to prior to the guidance. Initial data from one sites showed an increase in total numbers of cases year on year. All except 3 patients had positive blood cultures. Our data also shows that mortality remains high due to IE (2012%–18% of patients died as a direct result of IE, 2013%–38%, 2014%–11%, 2015%–21%).

Conclusions Incidence of IE has increased subsequently to the universal change in NICE guidance. Mortality associated with IE being still high. Although this is a small initial study from one centre, data from our second site is being collated to add support to our findings.

135 SOURCES OF STREPTOCOCCAL BACTERAEMIA AND THEIR IMPLICATIONS FOR THE DIAGNOSIS OF INFECTIVE ENDOCARDITIS

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Introduction The diagnosis of infective endocarditis (IE) is dependent on the detection of a sustained bacteraemia with multiple positive blood cultures being major criteria in the Duke nosology for IE. The interpretation of a single positive blood culture growing pathogens that could cause IE, but that do not fulfil major Duke criteria, is a common diagnostic difficulty in patients with a febrile illness. This study was designed to examine the clinical outcomes in patients with streptococcal bacteraemias and to determine the proportion of these with a final diagnosis of IE.

Methods This was a retrospective descriptive analysis of patients with streptococcal bacteraemias between September-December 2012. IE was confirmed by a Consultant Microbiologist (JS) using the modified Duke criteria. The variables

Abstract 135 Table 1 Distribution of streptococcal species isolated in blood cultures and their aetiological role in cases of infective endocarditis according to age less than or greater than 18 years.

	Age <18		Age ≥18		Total
	IE (%)	Not IE (%)	IE (%)	Not IE (%)	
Streptococcus pneumoniae	0 (0)	4 (100)	0 (0)	27 (100)	31
Oral streptococci	0 (0)	16 (100)	5 (12.5)	35 (87.5)	56
Strep. bovis group (*gallolyticus*)	0 (0)	0 (0)	0 (0)	1 (100)	1
Beta-haemolytic streptococci	0 (0)	5 (100%)	2 (12.5)	14 (87.5)	21
Strep. anginosus group (*anginosus/intermedius/constelatus*)	0 (0)	1 (100%)	0 (0)	2 (100)	3