

reported a subjective improvement in symptoms and quality of life.

**Conclusions** Initiation of SV and dose optimisation in clinical practice represents a significant burden of additional work for heart failure teams. Dedicated, registrar-led outpatient clinics to monitor patients commenced on SV by heart failure specialists can successfully address this.

Prescribing within NICE TA388 guidelines in real world patients, there were similar drug tolerance and adverse event rates to those reported in PARADIGM-HF. However, the lower mean age within this particular population, who were carefully selected, may indicate that such findings are not representative of the entire heart failure population.

### 3 A RETROSPECTIVE AUDIT OF MINERALOCORTICOID RECEPTOR ANTAGONIST (MRA) AND DEVICE THERAPY FOLLOWING MYOCARDIAL INFARCTION (MI) COMPLICATED BY LEFT VENTRICULAR (LV) SYSTOLIC DYSFUNCTION

Jonathan Mailey, Daniel Nicholl\*. *Ulster Hospital, Dundonald*

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**Introduction** The EPHEBUS trial demonstrated that eplerenone reduces mortality and hospitalisation from cardiac events in patients with symptomatic LV systolic dysfunction (LVSD) or diabetes following MI with LVEF 40%. The SCD-HeFT and MADIT-II trials demonstrated a reduction in mortality with the use of primary preventative ICDs in heart failure with reduced ejection fraction (HF-rEF).

We conducted a retrospective audit of patients presenting with HF-rEF secondary to MI between 1/4/15 and 31/3/16. Our focus was on the initiation of MRA therapy, repeat assessment of LV function post MI and the use of device therapy if indicated.

**Aims** 1. Establish the proportion of eligible patients with a post MI LVEF 40% prescribed an MRA.

2. Identify whether patients with LVEF 35% are having LV imaging at 6–12 weeks and if severe LVSD persists whether device therapy is considered.

**Methods** Patients presenting with either NSTEMI or STEMI to The Ulster Hospital, Northern Ireland were identified using the hospitals MINAP database. Data regarding these patients was collected using electronic patient records and echo database. Each patient with an ejection fraction 40% with clinical heart failure or diabetes was considered eligible for MRA therapy provided not contraindicated by renal function or potassium.

In patients with LVEF 35% we examined whether a repeat assessment of LV function with either echo or cardiac MRI was undertaken, when it was performed, and if appropriate whether ICD/CRT had been implanted. Patients were not considered eligible for a device if they had a pre-existing device, precluding co-morbidities, failed to attend echo or if they had died as an in-patient.

**Results** 350 patients presented to our institution with MI. 326 of these patients underwent IP assessment of LV function. 24% of the patients had LVEF 40% and 17% had LVEF 35%. 14% of patients were considered appropriate candidates for MRA therapy, but only 47% of this cohort had been prescribed an MRA.

54 patients had LVEF 35%, however only 27 were appropriate candidates for device consideration. 85% of appropriate candidates had a repeat assessment of LV function with a mean time to repeat imaging of 107 days. 17% of these patients had ongoing severe LVSD with the remainder having improved to >35%. Only 25% of those with ongoing severe LVSD had an ICD inserted, 25% died prior to review and in 50% there was no documentation why device therapy had not been considered.

**Abstract 3 Table 1**

Variable	n (%)
Patients with MI	350 (100%)
IP assessment LV function	326 (93%)
LVEF 40%	77 (24%)
• Eligible for MRA	47 (14%)
MRA prescribed at discharge	22 (47%)*
LVEF 35%	54 (17%)
Eligible for device therapy	27 (50%)**
Not eligible for device:	8 (15%)**
• Died as IP	3 (6%)**
• Did not attend follow-up	5 (9%)**
• Device already <i>in-situ</i>	11 (20%)**
• Extensive co-morbidities	23 (85%)***
• Repeat LV assessment	4 (15%)***
• LVEF 35% on repeat LV assessment	1 (25%)****
• ICD implanted	

\* = percentage of patients meeting eligibility criteria for MRA

\*\* = percentage of patients with LVEF 35%

\*\*\* = percentage of patients with LVEF 35% and appropriate for device therapy

\*\*\*\* = percentage of patients eligible for primary preventative ICD after post discharge LV assessment

**Conclusions** This audit demonstrated that there is scope to improve our practice in the management of post MI patients with severe LVSD. Explanations for this may include staff education and resource pressures. The appropriate prescription of MRA therapy and implantation of ICDs have a big impact on mortality in this cohort. It is therefore of the upmost importance to address any potential barriers to compliance with guidelines in order to improve the quality of care that is delivered.

### 4 IRON DEFICIENCY IN HEART FAILURE PATIENTS IN ENGLAND: INSIGHTS FROM ANALYSIS OF HOSPITAL EPISODE STATISTICS

<sup>1</sup>James M Beattie\*, <sup>2</sup>Rani Khatib, <sup>3</sup>Ceri Phillips, <sup>4</sup>Simon G Williams. <sup>1</sup>Heart of England NHS Foundation Trust; <sup>2</sup>Leeds Teaching Hospitals NHS Trust and University of Leeds; <sup>3</sup>College of Human and Health Sciences, Swansea University; <sup>4</sup>Wythenshawe Hospital

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**Introduction** Iron deficiency (ID) has been shown to be present in about 50% of patients with heart failure (HF). Associated with a poor quality of life, impaired effort tolerance, and increased mortality, ID responds to appropriately provided iron therapy. In those admitted with HF, screening for ID is inconsistent, and the impact of this condition is uncertain.