Sensitivity/Specificity/PPV/NPV/Accuracy were 64.4/85.2/27.6/96.5/83.5 for $CTA_{DEBLOOM}$ and 75.0/81.6/25.8/97.5/81.1 for CTASTAND. $CTA_{DEBLOOM}$ specificity was significantly higher than CTASTAND (85.2% vs. 81.6%, p=0.017), with no difference between the algorithms in sensitivity (p=0.22), or accuracy (p= 0.09). Interobserver agreement was fair with both techniques ($CTA_{DEBLOOM}$k= 0.38, CTASTAND k= 0.37).

Conclusion Coronary calcification deblooming using a prototype post-processing algorithm is feasible and significantly reduces calcium blooming with an improvement of the specificity of the CTA exam.

17 COMPARISON OF NICE CLINICAL GUIDELINES 95 2010 AND 2016: A SINGLE CENTRE EXPERIENCE

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Introduction This study was aimed at assessing the effectiveness of updated NICE clinical guidelines 95 2016 (CG95 2016) in comparison to NICE CG95 2010.

Methods This study was carried out at the University Hospitals of Leicester NHS Trust by analysing retrospective data collected from the hospital electronic database. Statistical significance of the differences of mean number of investigations, investigation cost, functional studies and radiation exposure between the 2010 and 2016 groups were assessed.

Results There were 487 and 557 patients in the 2010 and 2016 groups respectively. While there were statistically significant (p<0.001) increases in the mean investigations and the mean radiation exposure in CG95 2016 group, the mean cost of investigations (p<0.001) and the mean number of functional studies (p=0.030) were less in CG95 2016 group. 565 patients had a zero calcium score and only three (0.5%) were positive for ischaemia on subsequent functional imaging. In the CG95 2010 group, 341(70.0%) had a risk score of < 30%. Of the 231 (67.7%) who had a zero calcium score, only two (0.7%) were positive for ischaemia on subsequent imaging.

Conclusion The increase in the number of CT coronary angiograms (CTCA) performed in CG95 2016 group is likely leading to increase in mean radiation dose and mean investigations per patient. We propose that if the risk score is <30%, calcium score should be performed as the first line investigation. If calcium score is zero, further investigation with CTCA is not recommended unless there remains clinical concern for coronary artery disease.

18 BSCI/BSCCT RESEARCH SUB-COMMITTEE SURVEY OF RESEARCH ACTIVITY AND CARDIOVASCULAR IMAGING RESEARCH PRIORITIES

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Aim The BSCI/BSCCT research sub-committee survey aims to assess research activity and barriers to research amongst the society members. In addition, a modified Delphi approach will be used to develop consensus opinion for prioritising research questions in cardiovascular imaging amongst BSCI/BSCCT members.

Methods All members of the BSCI/BSCCT have been invited to participate in the online survey. The survey covers whether people are currently involved in research or would like to be involved in research or audit, what are the perceived barriers to involvement in research, and the ways that the BSCI/BSCCT may be able to support the research community. A modified Delphi approach with three rounds of surveys will be conducted to establish research priorities in cardiovascular imaging amongst BSCI/BSCCT members. Research questions will be collected during the first survey, followed by two rounds of prioritisation. A steering group will analyse results of each round and identify questions ranked as being the highest priority for each subsequent round of the Delphi process.

Results We will present the initial results of this survey including current research activity, barriers to research and initial research question suggestions.

Conclusion It is anticipated that this modified Delphi process will establish research priorities in cardiovascular imaging which will be used to plan other BSCI/BSCCT activities.