Results Data between the Warfarin, Rivaroxaban and Edoxaban groups were analysed using a multivariate analysis. Warfarin was used as the reference group with age and gender as covariates. Acute thromboembolic, bleeding and other less common complications were compared (table 2). There were 4 complications (4.6%) in the warfarin, 2 (2.5%) in the Rivaroxaban and 2 (3%) in the Edoxaban groups, respectively. (P value = 0.9).

Conclusion This retrospective study demonstrated that uninterrupted Edoxaban is as safe and effective as warfarin and Rivaroxaban in patients undergoing atrial fibrillation/ flutter ablations. There was no significant difference in acute bleeding and thromboembolic complications.

36 IMPACT OF ATRIAL FIBRILLATION TERMINATION ON LONG TERM OUTCOME IN PERSISTENT ATRIAL FIBRILLATION PATIENTS UNDERGOING ACQMAP GUIDED ABLATION

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Introduction An acute response to ablation (arrhythmia termination or cycle length prolongation) is often presented as evidence of the significance of non-pulmonary vein (PV) mechanisms for AF maintenance and is an attractive procedural end point.

Objectives To investigate whether acute AF termination with ablation predicts long-term freedom from arrhythmia recurrence.

Methods We conducted a retrospective analysis of 100 patients who have undergone AcQMap (Acutus Medical) guided catheter ablation for AF at 3 UK centres. Acute success was defined as a spontaneous conversion to sinus rhythm (SR) during the ablation procedure. Long-term success was defined as freedom from any documented arrhythmia after a 3-month blanking period.

Results Mean follow up was 11 ±4 months. Baseline characteristics were well matched between groups except that a higher proportion of those with acute success were in SR at baseline (n=11, 28%, vs. n=6, 10%, p=0.022).

During follow up, 68% (27/40) of patients with acute termination were free of arrhythmia recurrence compared with 50% (30/60) of those who required DCCV, a non-statistically significant difference of 0.18, p = 0.083. Binomial logistic regression was performed to evaluate the combined effect of acute termination and baseline SR on long-term outcome. The logistic regression model was not statistically significant ($X^2 = 3.857, p = 0.145$). For those undergoing first time procedures (n=81) ablation to SR vs DCCV freedom from recurrent arrhythmia was 74% vs 51% (p=0.041). In those in AF at baseline (n=83) ablation to SR vs DCCV freedom from recurrent arrhythmia was 69% vs 56% (p=0.048).

Conclusion The relationship between acute ablation to SR and long-term outcome is unclear but may be important for certain subgroups. More work is needed to fully explore the significance of this endpoint.

Conflict of Interest None

37 YOU WANT MY ADVICE AND GUIDANCE? PERFORMANCE OF A CARDIOLOGY EMAIL ADVICE LINE TO GENERAL PRACTITIONERS

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Background Cardiologists at Worcestershire Royal Hospital have provided email advice and guidance for local general practitioners. The performance of this service has not been formally evaluated.

Methodology Data were collected prospectively throughout 2018 including patient demographics, GP practice, time/date of email and of response, the person responding, the nature of the clinical question and whether admission or clinic appointment was recommended. Patient records were reviewed two months after the email to evaluate outcome.

Results In 2018, 2157 email queries were received about patients with a median age of 68 years (IQR 53–77). 52% were male.

In total 2145 queries (99.44%) were sent on weekdays, mean of 8.25 per weekday. The median response time was 4 hours 19 minutes (IQR 1.78–17.45 hours), 14.6% received a response in under an hour, 86.1% of queries were responded to within 24 hours and 93.9% within 48 hours. Weekend emails explained the remainder.

Overall 91.4% of emails were received between 0800–1700 and 36.2% of responses were sent outside of this time. We estimate 215 consultant hours were taken replying (assuming 6 minutes/email) equivalent to 54 programmed activity (PA) episodes.

The most common queries related to interpretation or management of ECGs (44%), ambulatory ECG monitoring (12.5%) or echocardiography (9.2%).

In total 73 GP Practices sent emails (mean of 28.6 queries/practice) of which 63 (86.3%) were from the Worcestershire CCG area. Worcestershire GPs accounted for 97.5% of all queries.

Variation exists between individual practices: three did not send any email queries; seven sent only one query over the year and one practice sent 179 queries (8.6% of total). If all practices participated as frequently, the number of emails received would increase five-fold to over 10,000 a year.

Of the 10 Cardiologists within the department, not all participated equally with three consultants replying to 63% of all emails and one replying to 30%.

Admission to hospital was recommended in one case and referral to outpatient clinic was recommended in 501 of 2152 cases (23.2%). Of these, a referral was only received within two months in 60.6% of cases.

We estimate that this initiative avoided up to 1493 clinic appointments (124 Consultant PA episodes or 2 per week).

Potential cost savings to CCG (1493 × £168 for cost of new outpatient consultation) = £250,824. Potential revenue to cardiology for ECG interpretation (44% of 2153 × £25 = £23,683) and for 24 hour holter interpretation 12.5% of 2153 × £45 = £12,110

(Price estimate from NICE Remote ECG interpretation consultancy services for cardiovascular disease MIB152)

Conclusion A cardiology advice and guidance email service is highly efficient use of specialist consultant time with a large