Abstract 46 Table 1 patient demographics and procedural characteristics

	Planned day case (n=129)	Planned overnight stay, same-day discharge (n=40)	Planned overnight stay (n=283)	P-value
Age/years	59.9 ± 10.2	60.9 ± 9.2	60.3 ± 9.9	0.831
Male	90 (69.8)	29 (72.5)	207 (73.1)	0.778
Distance/miles	29.9 ± 19.0	35.1 ± 25.2	36.8 ± 23.6	0.014
AF type				0.002
Paroxysmal	105 (81.4)	27 (67.5)	182 (64.3)	
Persistent	24 (18.6)	13 (32.5)	101 (35.7)	
Ablation method				0.081
Carto	32 (24.8)	22 (55.0)	160 (56.5)	
Cryo	63 (48.8)	10 (25.0)	64 (22.6)	
PVAC	34 (26.4)	8 (20.0)	49 (17.3)	
Acutus	0	0	10 (3.5)	
Procedure time/ mins	137 ± 36.3	147.3 ± 41.7	160.9 ± 48.6	<0.001
Morning start	110 (85.3)	35 (87.5)	107 (37.8)	<0.001
GA	30 (23.3)	19 (47.5)	173 (61.1)	<0.001
Redo	20 (15.5)	17 (42.5)	82 (29.0)	0.015

Values presented as mean±SD or n (%)

was an improved outcome in the intervention group. Randomization was 1 to 1.

Results Of the 97 participants available for randomization, 46 underwent teaching using the e-learning package and 51 were taught in the lecture group. Mean scores were higher in the e-learning package group than the lecture group, though this difference was not statistically significant (3.63 vs. 3.37; $P = 0.085$) immediately after intervention. At 2-weeks post intervention, mean scores in the e-learning package group was significantly higher than the mean scores in the lecture group (3.59 vs. 2.86; $P = 0.002$). This was despite a sub-analysis of the results demonstrating that subjects in the lecture group had seen more cases which was statistically significant compared to those in the e-learning group (32 vs. 13; $P = 0.002$).

Conclusion E-learning seems to be the preferred method of learning and the method that confers longer retention time for both post-graduate and undergraduate medical students.

Conflict of Interest None

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FEASIBILITY AND ECONOMIC IMPLICATIONS OF AMBULATORY AF ABLATION: A SINGLE-CENTRE EXPERIENCE

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Introduction The widely accepted model for AF ablation involves overnight hospital stay post-procedure. Given the rising incidence of AF and number of AF ablations performed, streamlining of practice to minimise overnight stay could

result in a significant reduction in waiting list times and procedure-related healthcare expenditure.

Day case AF ablation has been carried out at Royal Papworth Hospital (RPH) since early 2017. We evaluated the feasibility, safety and efficacy of day case AF ablation at RPH.

Method Retrospective, single-centre study of 452 consecutive AF ablations in 448 patients at RPH between March 2017 and April 2018. Ablation method was selected at the operator's discretion. Vitamin K antagonists were continued and direct oral anticoagulants withheld for one dose pre-procedure in line with departmental policy. Ultrasound was not routinely used for femoral venous puncture. Haemostasis post-sheath removal was achieved with manual pressure. The consultant listing the patient at initial assessment subjectively determined suitability for day case.

Complications were defined as any adverse procedure-related event. Success was defined as freedom from symptoms or demonstrable arrhythmia after 6 months following an initial 3-month blanking period.

Results Over the study period 129 out of 452 (28.5%) were planned day cases. Of these 128 (99.2%) were discharged on the same day; one patient was admitted due to late finish. 40 were performed as day cases despite being originally listed as inpatient procedures. Demographic and procedural data are summarised in table 1. There was no significant difference in age or sex between the groups. Of note, day case procedures were significantly shorter, more likely to commence in the morning and less likely to require general anaesthetic than overnight stays. Patients listed as day cases also had less far to travel.

Procedural outcomes are summarised in table 2. Overall complication rate was 3.3%, with no significant difference between groups. One planned day case was complicated by intraprocedural phrenic nerve palsy from which a full recovery

Abstract 46 Table 2 Procedural outcomes

	Planned day case (n=129)	Planned overnight stay, same-day discharge (n=40)	Planned overnight stay (n=283)	P-value
Complications				
Total	3 (2.3)	1 (2.5)	11 (3.9)	0.684
Vascular	0	0	5	
Tamponade	1	0	2	
Air embolus	0	0	1	
Phrenic palsy	1	0	0	
Migraine	1	0	0	
CVA	0	0	1	
Pulmonary oedema	0	1	1	
Leg numbness	0	0	1	
Death	1	0	0	
6 month success	102/128 (79.7)	28/40 (70.0)	205/280 (73.2)	0.710

Values presented as mean±SD or n (%)

was made and another by transient migraine. A further case resulted in atrio-oesophageal fistula and death 3 weeks post-discharge. One patient discharged the same day despite planned overnight stay presented to his local DGH 3 days later with pulmonary oedema.

Follow up data was available for 448 cases (99.1%). Procedural success rates were comparable between groups.

At a cost of circa £400 for an overnight stay in RPH the overall cost saving attributable to providing AF ablation as a day case was £67,200 over the 13 month period.

Conclusion

- Day case AF ablation is safe and efficacious even without strict standardisation of patient selection or procedural protocols in a high volume centre.
- Substantial reduction in healthcare expenditure can be achieved with more widespread implementation of ambulatory AF ablation.

Conflict of Interest nil

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PACE AND ABLATE STRATEGY IN PATIENTS WITH NEAR NORMAL LEFT-VENTRICULAR SYSTOLIC FUNCTION: PPM OR CRT?

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Introduction The European Society of Cardiology 2016 atrial fibrillation (AF) guidance suggests atrioventricular node (AVN) ablation and pacemaker implantation in patients with AF unresponsive to rate and rhythm control therapies.¹ For patients with conventional cardiac resynchronisation therapy (CRT) indications and AF, the recommendations are clear. However, in patients with normal left ventricular (LV) function and a pace and ablate strategy, there is limited evidence to support

biventricular pacing (CRT) in favour of conventional right-ventricular permanent pacemakers (PPM).

We audited our practice of AVN ablation to evaluate the current practice in our institution, and to observe for differences between pacing groups.

Methods Our devices database was searched for patients who underwent AV node ablation between June 2016 to September 2018. Descriptive and statistical analysis were performed, using t-test and Chi-squared methods.

Results 142 patients underwent AV node ablation, and 56 patients were identified with preserved LV function (LVEF > 50%) with a pace and ablate management strategy. Of these patients, 35 had a PPM, and 21 a CRT implanted prior to ablation.

Comparing these groups, patients undergoing pacemaker implantation were significantly older (PPM 76± 14 vs CRT 67± 11, p= 0.014). There was also a significant difference in male gender, (PPM 8 (22.9%) vs CRT 13 (61.9%), p= 0.0035).

Mean LVEF was similar between PPM and CRT groups (56±4% vs. 53±3%). There was a trend in higher background ischaemic heart disease in the CRT group (CRT 3 (14.2%) vs. PPM 1 (2.9%), p=0.108).

At initial device implantation, two patients intended for CRT had a failed attempt at LV lead placement (5.7%), therefore a PPM was implanted. Device procedure time appears longer in the CRT group (CRT 132.1 mins ± 40.9, vs. PPM 85.8 mins ± 34.8).

Total mean follow-up period was 345 days (± 197). Two patients (5.7%) in the PPM group required lead revisions, compared to none in the CRT group. A total of two patients required repeat procedures for failed ablations, with no other procedural complications. There was a trend in higher all cause mortality in the PPM group compared with the CRT group (4 (11.4%) vs. 1 (4.8%), p= 0.397).

Discussion and conclusion The BLOCK HF trial demonstrated that biventricular pacing was superior to right-ventricular pacing in patients with an LVEF <50%.² The role of