Abstract 48 Figure 1 Linq versus Confirm for patient reported outcomes

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DIAGNOSTIC YIELD OF IMPLANTABLE LOOP RECORDERS: A COMPARISON OF ARRHYTHMIA NURSE SPECIALISTS VERSUS CLINICIANS

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Background and aims Syncope guidelines recommend Implantable loop recorders (ILR) to aid symptom-rhythm correlation. Arrhythmia Nurse Specialists (ANS) are important in assessment of these patients. Their effectiveness at risk stratification is unknown. ESC 2018 Syncope guidelines recommend more research. Our aim was to evaluate the diagnostic yield of all

consecutive ILR implants over a 2-year period and compare ILR-guided management changes between ANS and clinicians.

Methods Retrospective study of consecutive patients undergoing ILR implant between April 2016-April 2018, including baseline patient demographics, referral source and management changes made by ILR findings.

Results 305 ILR patients were identified: median age 71 yrs (interquartile range 52–81), 45% female, median follow-up time 15months. Referrals were from general cardiology (GC) =98 (32%), electrophysiology (EP)=105 (34%) and ANS-led syncope clinic=102 (34%). Indications were syncope=203 (65.9%), palpitation=21 (6.9%), pre-syncope=16 (5.2%), cryptogenic stroke=35 (11.5%) and other reasons 7 (8.9%) (falls, channelopathies). Overall, 102 (34.0%) experienced arrhythmias detected on ILR that resulted in a change of management including: pacemaker implant=49 (16.1%), complex-device implant=7 (2.3%) and AF=28 (9.2%), SVT=14

Abstract 49 Table 1

		Clinicians n=203	ANS n=102	p value
Demographics	Median age/years (IQR)	67.9 (47.1-78.5)	76.4 (60.7-84.3)	<0.001
	Male/%	52.2	59.8	0.209
	Median time to follow-up /months	15.5	16.1	0.704
Indications	Syncope	112(55.2%)	91(89.2%)	<0.001
	Presyncope	13(6.4%)	3(2.8)	<0.001
Outcomes	AF	21(10.3%)	7(6.9%)	0.320
	Complex devices	5(2.5%)	2(2.0%)	0.782
	PPM	25(12.3%)	24(23.5%)	0.012
	Overall change in management	65(32.0%)	39(38.2%)	0.597

(4.6%), VT=1 (0.3%). ANS referrals resulted in greater trend towards change of management (38.2%) of patients compared with GC (32.7%) and EP (31.4%) ($p=0.593$ nurse vs. consultant). For those needing pacing, 24 were from ANS referrals compared to 25 for clinicians (23.5% vs 18.3% respectively, $p=0.012$). Median time to developing a pacing indication was 2.6 months for ANS and 4.1 months for clinicians; 25 had pacing indication within 3 months of ILR insertion. Overall, an ILR had a diagnostic yield of 34.1% ($n=104$) (table 1).

Conclusion The diagnostic yield of ILR insertion was 34%. ANS referrals trended towards greater diagnostic yield compared with clinicians and significantly more pacemaker indications. Our data suggest ANS patient selection for ILRs are at least comparable to clinicians.

Conflict of Interest None

Interventional Cardiology

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ISCHAEMIA AND NO OBSTRUCTIVE CORONARY ARTERY DISEASE (INOCA): PREVALENCE AND PREDICTORS OF CORONARY VASOMOTION DISORDERS

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Background Ischemia and no obstructive epicardial coronary artery disease (INOCA) is a common clinical syndrome with distinct underlying causes.

Objective To evaluate the prevalence and predictors of microvascular and/or vasospastic angina (MVA/VSA) in an unselected cohort of angina patients referred for invasive coronary angiography with suspected ischaemic heart disease in whom obstructive coronary artery disease (CAD) is excluded.

Methods Prospective cohort study at two regional centres between November 2016 and December 2017 including patients with symptoms and/or signs of ischaemia prior to undergoing invasive coronary angiography (NCT03193294). Baseline risk was assessed (ASSIGN score) and validated questionnaires were completed prior to the angiogram including Rose angina, quality of life (EuroQOL [EQ-5D-5L]) and angina severity according to the Seattle Angina Questionnaire (SAQ). Patients with definite or probable angina without CAD [diameter stenosis <50% and/or FFR > 0.80] proceeded directly to assessment for disorders of coronary vasomotion. This involved an ad hoc interventional diagnostic procedure (IDP) using reference invasive tests for microvascular angina (MVA), vasospastic angina (VSA), both conditions or none. MVA and VSA groups were compared before logistic regression was performed to assess predictors of MVA and VSA.

Results Three hundred and ninety-one patients with angina were recruited before undergoing invasive coronary angiography during the study period. Overall, 185 (47%) of subjects had INOCA and 151 of these underwent an IDP. INOCA patients reported similar angina burden with worse quality of life than CAD subjects (EQ5D-5L index 0.60 v 0.65 units;

Abstract 50 Figure 1 Prevalence of coronary vasomotion disorders as revealed by the IDP

The underlying abnormalities revealed by the IDP included: isolated microvascular angina (MVA) in 78 (51.7%), isolated vasospastic angina (VSA) in 25 (16.6%), mixed MVA/VSA in 31 (20.5%), and non-cardiac

Abstract 50 Figure 2 Differences in baseline characteristics (A) and quality of life (B) between MVA & VSA groups.

A - There were important key differences in baseline demographics notably a higher prevalence of dyslipidaemia (85% in MVA v 65% VSA) whereas smoking was more prevalent in the VSA group (36% VSA v 12% in MVA) MVA patients were more likely to have inducible ischaemia on ETT with a trend towards more typical exertional symptoms (Definite/typical defined by Rose Angina questionnaire). B - Angina severity and quality of life was worse in VSA compared to MVA subjects.

$P=0.041$). The mean age of patients who underwent the IDP was 60.9 years, 74% were female and their median predicted 10-year IHD risk was 18.6% (10.6, 31.4). 78 subjects (52%)