control group which was not significantly different (mean difference = 2.4 days, 95% CI = -0.5, 5.3 days, p = 0.1).

Conclusion UACDT is a safe procedure and although there is no difference in LOS with the procedure there is a potential that this difference will become more important as confidence with the procedure increases. There is a 12% incidence of occult cancer in this group of patients.

Conflict of Interest no

### Abstracts

#### 39 RELEVANCE OF THE ISCHEMIA TRIAL TO REAL-WORLD CLINICAL SERVICES

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Background The recently presented ISCHEMIA trial demonstrates that optimal medical therapy (OMT) is not inferior to an early interventional approach for patients with stable angina. These results have the potential to significantly impact on future care pathways. In the UK, the rapid access chest pain clinic (RACPC) is increasingly used as an open access resource. This study compared how the ISCHEMIA study may apply to real-world clinical services.

Methods Electronic notes of patients assessed in our high-volume Rapid Access Chest Pain Clinic (RACPC) within a 12-month period (2018–19) were reviewed. Patients retrospectively meeting key inclusion criteria for the ISCHEMIA trial were selected. Information on demographics, symptoms, initial investigations and management were obtained.

Results 2416 patients were assessed in the RACPC during the study period. Of these, 378 (15.6%) presented with symptoms thought to represent typical anginal chest pain (CP).

Within this group, 158 patients (41.8%) were excluded (62 due to ACS, 91 due to known CAD, 2 due to eGFR <30mL/min). This resulted in a total of 220 patients meeting key inclusion criteria of the ISCHEMIA trial, representing 58.2% of the typical chest pain population but only 9.1% of all patients seen in the RACPC. These patients had a median age of 60 years, 96 (44%) female, 44 (20%) had diabetes, 119 (54.1%) had hypertension and 32 (14.5%) were smokers.

From these 220 patients, 48 (21.8%) had a CT coronary angiogram (CTCA) as their first line investigation (42 completed). Of these patients, 1 (2.4%) patient had findings suggestive of significant left main stem (LMS) disease.

18 (8.2%) patients had stress echocardiography or stress perfusion CMR requested as their first line investigation (15 completed), 4 were positive for inducible ischaemia. 143 (65%) patients underwent invasive coronary angiogram (ICA) as their first line investigation (112 completed). In total 43 patients (19.5%) subsequently underwent revascularisation (8 patients for LMS disease, 11 patients due to multivessel disease, 24 patients treated with PCI). The median wait time for a CTCA was 55 days compared to 165.5 days for ICA.

See Table 1 for more details.

Conclusion In the real-world, patients present with undifferentiated chest pain, consequently the outcomes of the ISCHEMIA trial must be considered cautiously. Within our cohort of 2416 patients, only 220 patients met key inclusion criteria for the trial. Our patients were younger, more frequently female and not diabetic. Referral for invasive tests was the most common pathway, however service pressures resulted in a significant delay to treatment. Ultimately, only 19.5% received revascularisation, compared to 80% of patients in the invasive arm of ISCHEMIA. It is unclear how the results of the ISCHEMIA trial will ultimately impact on UK practice, but it is clear that OMT plays a central role.

#### REFERENCES


Conflict of Interest None

#### 40 SAPHENOUS VEIN GRAFT RADIO-OPAQUE MARKERS AND FEMORAL ACCESS REDUCE CONTRAST USE IN CORONARY ANGIOGRAPHY AND GRAFT STUDIES

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Background Saphenous vein grafts (SVG) are often employed for bypass in addition to internal mammary arteries during CABG operations. Despite the improvement in surgical
technique most post CABG patients will require additional coronary artery catheterization in their lifetimes. Radio-opaque markers for SVGs are safe and easy to implant during the CABG operation. The markers were found to have no impact on long term graft patency. However, these markers should make repeat coronary angiography and graft studies easier and allow these procedures to be performed with less contrast thereby reducing the risk of contrast induced nephropathy.

Methods We systematically reviewed consecutive diagnostic coronary angiograms of all patients with previous CABG at a single large Canadian interventional centre. Basic demographic and clinical data, access site, number of grafts, operator, and amount of contrast used were recorded for analysis. Predictors of amount of contrast used were identified using multiple regression analysis with stepwise elimination of factors utilizing SPSS software.

Results Between Jan 2016 and May 2019, 746 diagnostic coronary angiograms and graft studies were performed. 328 cases were excluded because the patients had additional procedures done in the same setting. Mean age of patients was 71 (9) years, 12 % were female. 41% of patients had a clip inserted at the time of their bypass surgery. 15% of patients had a single vein graft used at the time of surgery, 43% had two vein grafts and 42% of patients three or more grafts. 56 % of the procedures were performed via the femoral route.

Independent predictors of contrast volume used were access site (187 (64) ml for radial vs 170 (60) ml for femoral), number of grafts used (+ 24 ml per additional graft) and use of radio-opaque markers during CV surgery (166 (54) ml with surgical clips versus 186 (66) ml without clips). Age, gender and operator were not predictive of the amount of contrast used.

Conclusions Positioning graft markers at the time of CV surgery can significantly reduce the contrast requirement for subsequent cardiac catheterisation. Even in a high volume radial centre further reductions of contrast use can be achieved by using femoral rather than radial access.

Conflict of Interest None

Methods and Results We included all patients treated with MagicTouch DCB between March 2018 and June 2019. The results are reported as cardiac death, target vessel myocardial infarction, target lesion revascularisation (TLR) and MACE (combination of cardiac death, target vessel MI and TLR).

During the study period, 219-patients (with 243-lesions) with de novo lesions were treated with MagicTouch DCB. The mean age of patients were 66 +/- 10.7 years, 209 (77%) were male, 34% (n=75) had diabetes, 16% (n=34) had chronic kidney disease and 54% were in the setting of acute coronary syndrome (n=118). Predilatation was performed in 92% (222-lesions). Bailout stenting (with DES) was required in 13% lesions (n=32) and of which 18 were due to dissections and 14 were due to recoil >30% following DCB use. The mean diameter and length of DCBs were 2.29 mm and 24 mm respectively.

During a median follow-up of 313-days (10-months) cardiac death was reported in 3 patients (1.4%). Target vessel MI was in 1.4% (n=2), TLR per lesion was 6.5% (n=16) and the MACE rate was 5.5% (n=12). There were no documented cases of acute vessel closure.

Conclusion The mid-term outcome from the first ever study on sirolimus eluting balloon in de novo small vessel lesions appears promising with low rates of hard endpoints, repeat rates of revascularisation and MACE rates despite complex group of patients (50% ACS, 34% diabetics and 14% CKD) and lesion subsets (small vessel and diffuse disease). We need longer follow-up which is ongoing and we will be able to report the outcomes from even longer follow-up during the BCS.

Conflict of Interest None