Abstract 48 Table 1 Patient demographics, investigations and revascularisation

	Typical Chest Pain		ACS	
n=	378		80	
Mean age	67	(35 – 96)	68	(38 – 91)
Male	240	63.4%	55	68.8%
Hypercholesterolaemia	207	54.8%	41	51.3%
Diabetes	86	22.8%	16	20.0%
Family History CAD	170	45.0%	27	33.8%
Hypertension	209	55.3%	47	58.8%
Smoking history	209	55.3%	43	53.8%
History of CAD	105	27.8%	22	27.5%
First-line Investigation:				
CTCA	49	13.0%		
Stress echo	25	6.6%		
Stress CMR	13	3.4%		
ICA	259	68.5%	72	90%
Revascularisation:				
PCI	33	8.7%	35	43.8%
Inpatient Surgical	4	1.1%	10	12.5%
Outpatient Surgical	19	5.0%	0	0.0%
Total	56	14.8%	45	56.3%

Abbreviations: ACS, acute coronary syndrome; CAD, coronary artery disease; CTCA, computed tomography coronary angiography; CMR, cardiac magnetic resonance; ICA, invasive coronary angiogram; PCI, percutaneous coronary intervention

(ICA). 45 (56.7%) patients subsequently underwent revascularisation (35 underwent PCI, 10 underwent surgical revascularisation). 1 patient was found to have unobstructed coronary arteries and was diagnosed with severe aortic stenosis, subsequently undergoing inpatient aortic valve replacement. All patients underwent an echocardiogram, 31 (40%) patients were found to have a regional wall motion abnormality. On logistic regression of all variables within the ACS cohort including age, gender, risk factors and baseline ECG, only troponin was found to be a predictor of revascularisation (OR 2.76, CI 1.09-7.03, p value 0.03).

Conclusion The rapid access chest pain clinic is a valuable resource for prompt assessment of patients with suspected cardiac pain. Our experience suggests patients seen with typical angina represent a high-risk group with high rates of revascularisation, particularly in those with suspected ACS. Within our cohort, predictors of revascularisation were ACS presentation and male gender.

Conflict of Interest None

49 DAPT SCORE: CAN WE APPLY IT TO PRACTICE AND IDENTIFY THOSE AT RISK OF RECURRENT MAJOR ADVERSE CARDIOVASCULAR EVENTS?

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Introduction Approximately 20% of patients suffer from major adverse cardiovascular events (MACE), within 5 years of stopping dual antiplatelet therapy (DAPT), following an acute coronary syndrome (ACS) event. As such, prolonged DAPT, with aspirin and ticagrelor, has shown significant reductions in MACE, offset by an increased risk of major bleeding. The DAPT score offers a means to predict those who would derive benefit from prolonged therapy. We sought to evaluate applicability of the DAPT score to our population in a tertiary heart attack unit.

Method

Anonymised data was reviewed as part of a larger quality improvement initiative associated with management of ACS. ACS was defined according to standard international criteria. DAPT scores were calculated and compared against our cohort of patients who would have met criteria for prolonged DAPT as per PEGASUS. Patients were excluded if they were at high risk of bleeding, as assessed using CRUSADE scores ≥ 41, or required anticoagulation.

Results Between September to December 2019, 304 patients presented with ACS, of which 89 patients were excluded due to high bleeding risk (56) and concomitant anticoagulation (33). 38 patients were excluded as there was insufficient data to calculate DAPT scores. Of the remaining 177 patients, 55% met PEGASUS criteria for prolonged DAPT, largely driven by multivessel disease (66%). When undertaking the DAPT score, this suggested benefit from prolonged DAPT in 53% of patients meeting PEGASUS criteria.

Conclusion Applying the DAPT score identified just upward of 50% of patients that may benefit from prolonged DAPT. Patients over the age of 65 is a key inclusion criterion in PEGASUS that derived benefit from prolonged therapy; however, is also a risk factor for major bleeding and as such, a negative predictor factor in the DAPT score. This may contribute to the 50% of patients who met criteria for prolonged DAPT as per PEGASUS but would not warrant prolonged DAPT when applying the DAPT score. This review suggests that risk stratification through use of a suitable risk tool (DAPT score) may help to widen the risk benefit of prolonged DAPT by excluding those likely to bleed while ensuring patients at highest ischemic risk are appropriately targeted.

Conflict of Interest None

50 CLINICAL OUTCOMES FOLLOWING BAILOUT STENTING IN PATIENTS TREATED WITH PACLITAXEL COATED BALLOON VERSUS SIROLIMUS COATED BALLOON; SYNERGY OR TOXICITY?

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Aims The bailout stenting post-drug coated balloon (DCB) is performed with second generation drug eluting stents (DES). For paclitaxel DCBs (PCB), it will result in delivery of 2 different drugs to the vessel wall (Paclitaxel from DCB + Limus from DES), on the contrary for sirolimus DCBs (SCB) it will result in double dose of a same drug (Limus from DCB + Limus from DES). In this study, we study the differences in the clinical outcomes between the two groups (PCB + Limus stent vs. SCB + Limus stent) assessing for either a synergistic or a toxic-effects.

Methods and Results We evaluated patients treated with DCB between January 2016 and June 2019 at our centre. Results