different outcomes exist after HF programme completion based on body mass index (BMI).

Methods A multi-centre retrospective observational study was carried out in 3 hospitals' HF clinics. New patients referred to each HF service over a 12 month period were reviewed, or in a 24 month period in one centre, with a left ventricular ejection fraction (LVEF) < 50% were eligible for inclusion. Patient records were obtained to collect patient demographics, New York Heart Association (NYHA) class symptoms, NT-proBNP, LVEF and medications at initial referral and at programme completion. Hospitalisation rate for HF and mortality was also noted. Patient characteristics and outcomes were compared between non-obese (BMI < 29.9) and obese (BMI > 30).

Results 93 patients were included for analysis and a follow up of (mean ($\pm$ SD) 16.5 months ($\pm$ 8.8) was obtained. 63 (67.7%) had a BMI < 29.9 and 30 (32.3%) had a BMI > 30. Obese patients were more likely to be male ($p=0.03$), diabetic ($p=0.05$) and have hypertension ($p<0.001$). No significant differences in medical or device therapy was noted between groups. Obese patients had a greater improvement in their LVEF following programme completion (10.5% ($\pm$ 11.7) versus 7.95% ($\pm$ 10.7)), although this did not reach statistical significance ($p=0.34$). Obese patients had significantly lower NT-pro BNP levels at HF programme completion (median(IQR)) (546.4 () versus 962 (), $P=0.02$) however this improvement was not significantly greater than that seen in non-obese patients ($p=0.8$). Although no difference in mortality was noted between the groups (8 (12.7%) versus 3 (10%), $p=0.73$), obese patients had significantly fewer HF hospitalisations than the non-obese group (0.33 ($\pm$ 0.74) versus 0.04 ($\pm$ 0.2), $p=0.005$).

Conclusion Despite higher rates of diabetes and hypertension in obese patients, there was no significant difference in mortality, LVEF improvement and NT-proBNP improvement following HF programme completion between the 2 groups. However, obese patients had significantly less HF hospitalisations during the study period than non-obese patients.

21 INFECTIVE ENDOCARDITIS POST-TRANSCATHETER AORTIC VALVE IMPLANTATION: EXPERIENCE FROM AN IRISH TERTIARY REFERRAL CENTRE

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10.1136/heartjnl-2020-ICS.21

Background Prior studies of infective endocarditis (IE) post-transcatheter aortic valve implantation (TAVI) have reported an incidence of 1–2%, a median time from TAVI to presentation with IE of ~1 year, and 1-year mortality rates of 40–50%. In addition, a higher rate of enterococci as the culprit microorganism compared to staphylococci and streptococci has been reported.

Objectives To determine the clinical characteristics, microorganism spectrum, and outcomes of IE post-TAVI in an Irish tertiary referral centre.

Methods Using a prospective TAVI database, all patients diagnosed with IE post-TAVI were identified. Pre-defined baseline demographic, procedural and follow-up data were analysed. Specific additional retrospective analysis of medical records

Abstract 21 Table 1 Culprit Micro-organism

Culprit microorganism	N (%)
Streptococci	7 (41.1)
Strep mitis	2 (11.7)
Strep salivarius	2 (11.7)
Strep infantarius	1 (5.8)
Strep gordonii	1 (5.8)
Abiotrophia Defectiva	1 (5.8)
Enterococcus faecalis	3 (17.6)
Staphylococci	3 (17.6)
Staph aureus	1 (5.8)
Coagulase-negative staph	2 (11.7)
Culture Negative	4 (23.5)

Survival probability estimate at one year is 0.82 (95% CI = 0.55–0.95)

Abstract 21 Figure 1 Survival curve at 1 year for IE post-TAVI

were performed to assess the culprit microorganism and treatments for IE.

Results A total of 707 patients underwent TAVI during the study period. During a mean follow-up of 2.3 years, 17 (2.4%) patients with IE were identified. According to the modified Duke criteria, IE was defined as definite and probable in 6 (35%) and 11 (65%) cases, respectively. The mean age was 78.7 ($\pm$ 13.7) years and 12 (71%) were male. The median time from TAVI to presentation with IE was 7 months (IQR 5–13). The dominant culprit microorganisms identified were streptococci (41.1%), with a low frequency of enterococcus faecalis (17.6%) (table 1). Among the 17 patients with IE, there was one (6%) major stroke and two patients (12%) required surgical aortic valve replacement. There was one death during the initial hospitalization for IE. The Kaplan-Meier estimate of survival at 1 year was 0.82 (95% CI = 0.55–0.95) (figure 1).

Conclusions This Irish TAVI cohort exhibited a similar incidence of IE post-TAVI and similar time to first presentation compared to prior international registries. There was a much lower rate of enterococcus compared to staphylococci and streptococci as the culprit microorganism. The 1-year mortality rate in this series was much lower than previously reported.