a 6-monthly LDL-C >1.8 mmol/L and were on high dose statin therapy, we included these patients in our final analysis, resulting in 37.1% (111/299) patients in our cohort being eligible for a PCSK9i based on current ESC guidelines, results are summarized in figure 1.

**Discussion** Our results highlight the discrepancy between current ESC/EAS guidelines and the reimbursement criteria for PCSK9i in Ireland. This discrepancy results in minimal patients with coronary artery disease being eligible for a PCSK9i in Ireland. The results also highlight that a significant proportion of patients in clinical practice do not meet LDL-C goals post cardiac rehabilitation, these targets should be met in order to reduce future cardiovascular risk and improve outcomes for patients.

**3 IMPACT OF MORBID OBESITY AND OBESITY PHENOTYPE ON OUTCOMES POST TRANSCATHETER AORTIC VALVE REPLACEMENT**

A propensity-score matched analysis was performed matching MO and NO patients on a 1:1 basis to assess differences in outcomes between groups. A multivariate analysis was undertaken to determine predictive factors for all-cause mortality at 2 years in the MO group.

Pre-TAVR computed tomography scans were analyzed in a centralized core laboratory to assess adipose tissue distribution based on epicardial fat (EAT), abdominal visceral (VAT) and subcutaneous fat (SAT), and to evaluate its impact on outcomes.

**Results** A total of 3174 patients undergoing TAVR were included: 2264 in the NO and 910 in the MO groups respectively. After propensity score application, a matched cohort with 770 patients per group was obtained. Groups were well matched although some baseline cardiovascular risk factors, such as hypertension, hyperlipidaemia and diabetes mellitus, continued to differ. Major vascular complications (MVC) occurred more commonly (6.6% vs 4.3%, p=0.043) and device success was lower (84.4% vs 88.1%, p=0.038) in the MO group. After a median follow up of 14.11 months [IQR 6.47–36.01], survival analysis demonstrated similar rates of all-cause and cardiovascular mortality for matched MO and NO groups (79.4 vs 80.6% p=0.731 and 88.7 vs 87.4% p=0.699 respectively). Decreased baseline hemoglobin, non-transfemoral vascular access, MVC, stage 2–3 acute kidney, and periprocedural stroke were all independent predictors of 2-year mortality.

Adipose tissue distribution analysis identified an adverse MO phenotype whereby abdominal VAT:SAT ratio ≥1 was associated with increased 2-year all-cause (HR 3.06, 95%CI 1.20–7.77, p=0.019) and cardiovascular (HR 4.11, 95%CI 1.06–15.90, p=0.041) mortality, and readmissions (HR 1.81, 95%CI 1.07–3.07, p=0.027). Additionally, increased all-cause mortality at 2 years was found for each 10 cm3/m2 increment in indexed EAT (HR 1.16, 95% CI 1.03–1.30, p=0.011). After multivariable analysis, VAT:SAT ratio ≥1 remained a strong predictor of 2-year mortality (HR 2.78, p=0.035).

**Conclusion** MO patients undergoing TAVR demonstrate similar periprocedural and mid-term outcomes to a matched cohort of NO patients. Higher rates of MVC in the MO group highlight the need for vigilance when performing vascular access. VAT:SAT ≥1 identifies an obesity phenotype at higher risk of 2-year mortality and readmission.