according to the 'I NEED HELP' criteria are outlined in table 1. Notably, 69% of the cohort had ≥ 3 markers of advanced HF. At the time of clinic review, 28% (n=9) required urgent admission for further assessment and management, almost all (89%, 25% of total cohort) of these requiring inotropes. Out of the total cohort, 31% subsequently underwent MCS implantation (median: 33 ± 13 days) or heart transplantation (median 38 ± 22 days) (table 2). At time of clinic visit, 37.5% had a relative contraindication to transplantation with 16% having ≥ 2 , the most frequently observed being elevated body mass index (BMI) $>30 \text{ kg/m}^2$, excess alcohol intake and renal dysfunction with an estimated glomerular filtration rate $< 30 \text{ ml/min/1.73 m}^2$.

Conclusion Referrals to the National Advanced HF service in Ireland are presenting at an already markedly advanced stage, with over two-thirds having 3 or more established markers of advanced HF, a quarter requiring direct admission leading to inotropes, and almost a third proceeding to advanced surgical therapies. In addition, more than one third of patients referred had a relative contraindication identified at first consultation, with lifestyle factors accounting for a significant proportion. These findings have implications for development of formal referral pathways and greatly increased resource provision to a hitherto understudied cohort to enable optimal assessment and management for this patient group.

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A REVIEW OF PATIENTS WITH HEART FAILURE WITH MID-RANGE EJECTION FRACTION (HFmrEF): CO-MORBIDITIES AND OUTCOMES

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Background The ESC now recognises HF patients with a left ventricular ejection fraction (LVEF) of 40%-49% as having a distinct phenotype, referred to as Heart Failure with mid-range Ejection Fraction (HFmrEF).

This classification was implemented to promote research in this group of heart failure (HF) patients.

Aims We aimed to compare the co-morbidities of HFmrEF patients with those of Heart Failure with preserved Ejection Fraction (HFpEF) and Heart Failure with reduced Ejection Fraction (HFrEF) patients, and aimed to compare hospitalisations for acute decompensation HF, and mortality between these groups.

Methods All new referrals to a HF clinic in three neighbouring hospitals were included between January 1st 2017, and December 31st 2017. Data was collected on co-morbidities associated with each HF classification. Mean follow up was 17.5 months (± 7.6) and we recorded hospitalisations for ADHF and mortality data.

Results 286 new patients were referred to one of our 3 HF clinics; following optimisation, the patients were divided as: HFpEF 67 (23.4%), HFmrEF 58 (20.3%), HFrEF 94 (32.9%). 69 patients did not have a repeat echocardiogram. Table 1 presents the co-morbidities. Categorical data was analysed with Chi-square testing and continuous data analysed with unpaired t testing. Significance in HFrEF and HFpEF is in comparison with HFmrEF. Figure 1 is a Kaplan Meier curve demonstrating the events across the follow-up period.

Abstract 47 Table 1 Co-morbidities

	HFmrEF	HFrEF	P value	HFpEF	P value
Age, mean (SD)	69.4 (14.6)	66.2 (12.1)	0.15	72 (14.0)	0.39
Ischaemic, n (%)	22 (39.2)	49 (52.1)	0.13	28 (41.8)	0.78
NYHA I, n (%)	14 (25)	19 (20.2)	0.49	16 (23.9)	0.89
Diabetes, n (%)	13 (23.2)	19 (20.2)	0.66	22 (32.8)	0.24
Hypertension, n (%)	25 (44.6)	49 (52.1)	0.38	42 (62.7)	0.04
MI, n (%)	23 (41.1)	45 (47.9)	0.42	19 (28.4)	0.14
CABG, n (%)	3 (5.4)	21 (22.3)	0.006	12 (17.1)	0.03
PCI, n (%)	19 (33.9)	36 (38.3)	0.59	17 (25.4)	0.30
AFib/Flutter, n (%)	26 (46.4)	42 (44.7)	0.84	38 (56.7)	0.26
Hospitalisations (mean (SD))	0.23 (0.54)	0.34 (0.74)	0.37	0.34 (0.69)	0.35
Mortality, n (%)	6 (10.7)	12 (12.8)	0.71	9 (13.4)	0.65

Abstract 47 Figure 1 Events across the follow-up period

Conclusion Co-morbidities were similar in HFmrEF as compared with HFpEF and HFrEF, aside from previous CABG surgery (fewer in HFmrEF as compared with HFpEF and HFrEF) and HTN (there were more in HFpEF). Mortality was similar across the 3 groups over our follow up period of 17.5 months, and there was no difference in mean hospitalisations for ADHF between the groups. In our catchment area, our HFmrEF have a similar phenotype to our HFpEF and HFrEF cohorts.

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TREATMENT OF HEART FAILURE IN 2020: CHAMPS OR CHUMPS?

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Introduction The importance of achieving target doses of guideline directed medical therapy (GDMT) for patients with heart failure with reduced ejection fraction (HFrEF) is well established. Recently, large registry studies conducted in both the United States (CHAMP-HF) and in Europe (CHECK-HF) have identified while much progress has been made compared with similar studies in the early part of the millennium, significant deficiencies in prescribing trends and adherence to guidelines still remain. Our goal was to conduct an audit of prescribing trends in a tertiary referral centre at University Hospital Galway, within a specialist-led heart failure outpatient