were 3 true positive results, 1 true negative and 7 false negative results.

**Conclusion** In this study almost 20% of the cohort underwent PET CT scanning, often in the most clinically challenging and complex cases where the diagnosis is uncertain and guiding surgical referral. Of these only three results were positive for peri-valvular uptake or embolic spread. Two patients had increased uptake in the ascending aorta which was of unknown significance, but was not counted as a positive scan result.

The results in our cohort were not as helpful as reported in other international series. Despite the fact that our numbers were small and used in highly selected cases, they suggest caution in the use of PET-CT in IE. This is particularly pertinent for negative scan results, as 3 of our patients with no cardiac uptake on PET-CT had IE diagnosed pathologically. This highlights the importance of including all the clinical and imaging information in the decision-making algorithm for IE.

**INCIDENCE, CLINICAL IMPACT AND PREDICTORS OF THROMBOCYTOPENIA AFTER AORTIC VALVE REPLACEMENT WITH TRANSCATHETER OR SUTURELESS HEART VALVES**

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**Background** Thrombocytopenia is a poorly understood complication after surgical (mechanical or biological) (SAVR) and transcatheter aortic valve replacement (TAVR). The etiology of this platelet count decrease remains unknown. A higher incidence of thrombocytopenia has been associated with suturless-SAVR (S-SAVR) and transcatheter balloon-expandable valves (BEV) compared to stented and self-expandable valves (SEV), respectively. However, its clinical impact, and furthermore the best cut-off point to predict clinical outcomes has not been elucidated.

**Objectives** The objective of this study therefore was to analyze the incidence, clinical impact and predictors of thrombocytopenia in patients undergoing transcatheter (TAVR) or S-SAVR replacement.

**Methods** Consecutive patients (n=760) with severe aortic stenosis undergoing TAVR (n=679) or S-SAVR (n=81) in a single center between September 2007 and September 2018, and who did not have baseline thrombocytopenia, were included. Patients were classified according to the nadir platelet count, and the time-to-nadir: early nadir (<4 days) or late nadir (greater than or equal to 4 days) post procedure. Receiver Operating Characteristic (ROC) curves for early (30-day or in-hospital) mortality were performed using nadir platelet count and percentage decrease in platelet count. Mid-term mortality was defined at 2-years. Clinical outcomes were defined according to Valve Academy Research Consortium (VARC-2) criteria.

**Results** The median percentage decrease in platelet count was 37.8% [IQR: 28.8–48.4], resulting in moderate (<100*10^9/L) and severe (≤50*10^9/L) thrombocytopenia in 28.8% and 4.2% of patients, respectively. BEV had a lower incidence of moderate-severe thrombocytopenia (27.6%) compared with SEV (37.7%, p=0.008) and S-SAVR (51.9%, p<0.001). Percentage decrease in platelet count showed a greater area under the curve by ROC analysis than absolute platelet nadir for predicting early mortality with the optimal cut off for percentage platelet decrease being greater than or equal to 46% (sensitivity: 79.0% and specificity: 70.6%). Percentage decrease in platelet count greater than or equal to 46% predicted early mortality with an odds-ratio of 4.8 (95%CI: 2.0–11.5). Late nadir platelet was also an independent predictor of early mortality (OR: 4.6, 95%CI 2.1–10.0). The combination of both factors (greater than or equal to 46% and greater than or equal to 4 days) predicted higher 2-year mortality (51.6%) compared to an early significant nadir (greater than or equal to 46% and <4 day, 24.0%) and non-significant nadir (<46%, 20.2%), p<0.001 for both comparisons.

**Conclusions** Moderate-to-severe thrombocytopenia occurred in approximately one third of patients after TAVR or S-SAVR. Percentage decrease in platelet count best predicted short-term clinical outcomes. Only late and significant platelet decrease was associated with mid-term mortality.
assessments (45.49 vs 47.06% p=0.843 for ISR and de-novo groups respectively).

FFR was the mostly commonly used physiological modality to defer revascularization across both groups (used in >75% of cases). The average FFR was 0.86 across both groups (p=0.569), with the average iFR being 0.93 in the ISR group vs 0.94 in the native artery group, p=0.302. At 36-month follow up there were no differences in freedom from MACE by Kaplan Meier estimates 84.77 vs 86.08%, log rank, p=0.75 for ISR and native arteries respectively (figure 1). Neither were there differences in the individual components of the composite end point: all-cause mortality (91.70 vs 90.01%, log rank p=0.75), TLR (92.73 vs 95.84%, log rank p=0.35) nor TVMI (98.45% vs 100%, log rank p=0.1536) for ISR and native vessels respectively.

Conclusions Deferral of revascularization in patients with moderate ISR is safe in comparison to a matched group of native vessel moderate stenosis with no differences in a composite MACE end point at 36 months between groups.

**Oral abstract presentations 2**

**10 LEFT ATRIAL FUNCTION BY ECHOCARDIOGRAPHY IS INDEPENDENT OF DEGREE OF LEFT ATRIAL ELECTRICAL SCAR**

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**Introduction** Assessment of left atrial function via transthoracic echocardiography (TTE) is often performed by measuring the transmitral A wave in sinus rhythm. Left atrial (LA) fibrosis plays an important role in the pathogenesis and perpetuation of Atrial Fibrillation (AF). It may be identified by bipolar voltage (BiV) mapping, which can easily be performed at the beginning of a Pulmonary Vein Isolation (PVI) procedure. The relationship between the degree of LA fibrosis, characterized with mapping, and LA function, determined by echocardiography, has not previously been elucidated.

**Methods** Patients were enrolled in a project to evaluate the degree of fibrosis during PVI procedures. Pre-procedure TTEs of those presenting in sinus rhythm were assessed and the transmitral A wave was measured and compared to the degree of scarring seen. The high density electroanatomic maps (HD-EAMs) created during the PVIs were analyzed using a novel VHA algorithm after the procedure. All points with voltages < 0.5 mV were defined to have electrical scar. Patients were classified into 4 quartiles based on the levels of scar seen (figure 1).

**Results** 39 patients were included in the evaluation. Average age was 60.6 ± 13.2 years. 32 (82.0%) of the patients were male. Mean CHADS2VASc score was 1.5. The mean percentage of scar was calculated as 19.6 ± 15.9%. The average A wave was 0.62 ± 0.18 ms-1. Pearson’s correlation coefficient showed no relationship between LA scar and either A wave.