

Abstract 22 Table 2 Overall rates of pre-pregnancy counselling

Did the patient receive pre-pregnancy counselling?	Number	Percentage (of total participants)	Was the risk quantified?	Number	Percentage (of pre-pregnancy counselling group)
Yes	161	66.8%	Yes	52	32.3%
			No	109	67.7%
No	80	33.2%			

omits any pre-pregnancy counselling that was not documented or pre-dated the use of electronic records.

Conclusions 66.8% of women with known cardiovascular disease were given pre-pregnancy counselling (target 100%). As such, a quality improvement initiative is being established to improve provision of pre-pregnancy counselling to all women of child-bearing age with cardiovascular disease.

Conflict of Interest None

REFERENCE

- 2018 ESC Guidelines for the management of cardiovascular diseases during pregnancy. *EJH* 2018;**39**:3165–3241

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FEASIBILITY ASSESSMENT FOR THE IMPLEMENTATION OF A VIRTUAL HYPERTROPHIC CARDIOMYOPATHY FOLLOW UP CLINIC IN A DISTRICT GENERAL HOSPITAL

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10.1136/heartjnl-2021-BCS.23

Background The COVID-19 pandemic has presented unprecedented challenges for day-to-day medical practice. In some hospitals face-to-face clinic consultations have significantly reduced, being replaced by virtual clinics where possible. We hypothesised that virtual follow up of many of our Hypertrophic Cardiomyopathy (HCM) patients could continue indefinitely without impacting on the quality of clinical care, with the overall benefits of maintaining patient safety and convenience, and reduced costs for the hospital.

Purpose The purpose of this study was to evaluate physician consultations in our HCM clinic prior to the COVID-19 pandemic to determine what proportion of consultations resulted in patients developing new symptoms or requiring medication changes. We further looked to see if we could identify any patient factors that would allow us to predict which patients would be most suitable for future virtual follow up.

Methods We retrospectively reviewed the electronic patient records of HCM patients seen in the dedicated Inherited Cardiac Conditions (ICC) clinic for follow-up over a 6-month period in 2018. Patients were classified into high ($\geq 6\%$), moderate (4-5.9%) and low ($< 4\%$) risk groups according to ESC-SCD risk score. Transthoracic echocardiogram and cardiac magnetic resonance features were reviewed. The outcome comprised number of patients developing new symptoms or requiring medication change, as well as hospital admissions for cardiovascular reasons (e.g. angina, arrhythmia, and heart failure) in the 2-years following clinic consultation.

Results Forty-seven HCM patients (mean age 61.4 ± 12.2 , 55% male) were identified and reviewed from the ICC

Abstract 23 Table 1 Demographics and the number of follow-up HCM patients who developed new symptoms or required medication changes and their respective ESC-SCD risk categories

A total of 47 follow-up HCM patients were identified over a 6-month period in 2018

Age	61.4 \pm 12.2			
Male Gender	26			
ESC-SCD Risk Stratification	N	Developed New Symptoms	Required Medication Changes	Cardiac admissions in 2-years
Low	38	8 (21%)	11 (29%)	2 (5%)
Moderate	4	1 (25%)	2 (50%)	0 (0%)
High	4	1 (25%)	2 (50%)	0 (0%)

Abstract 23 Table 2 The number of follow-up HCM patients who developed new symptoms or required medication changes and their respective echocardiography and cardiac magnetic resonance assessments. EF, ejection fraction; LA, Left atrium; LVOT, left ventricular outflow tract

Echocardiography	N	Developed New Symptoms	Required Medication Changes	Cardiac admissions in 2-years
LVOT obstruction	14	1 (7%)	3 (21%)	0 (0%)
LV systolic dysfunction (EF \leq 50%)	3	0 (0%)	2 (67%)	1 (33%)
LV diastolic dysfunction (Grade II-III)	2	0 (0%)	1 (50%)	1 (50%)
LA diameter \geq 45mm	12	3 (25%)	4 (33%)	0 (0%)
LA area \geq 30mm ²	12	3 (25%)	4 (33%)	0 (0%)
Cardiac Magnetic Resonance				
Late-gadolinium enhancement	17	3 (18%)	4 (24%)	0 (0%)

clinic. Overall, 36% of patients had interventions from the face-to-face clinic; with 21% of patients developing new symptoms and 32% of patients requiring medication changes. There were 38 low-risk, 4 moderate-risk and 4 high-risk patients. 1 patient was not eligible for the risk stratification due to age over 80. 21% of low-risk, 25% of moderate-risk and 25% of high-risk patients developed new symptoms (**table 1**). Over 50% of patients who had a moderate-high ESC-SCD risk score or echocardiographic evidence of systolic/diastolic impairment required medication changes (**table 1 & 2**). Only 2 patients had hospital admissions for cardiovascular reasons in the 2-year follow up period, and those with systolic/diastolic impairment also incur high rates of admissions (**table 2**).

Conclusion About 60% of HCM patients from our inherited conditions clinic were asymptomatic and did not require changes in medication, which suggests that this group would be very suitable for virtual follow-up clinic appointments post-pandemic. Potential predictive factors would include patients with low ESC-SCD risk score and without left ventricular impairment. Hospital costs may be reduced whilst maintaining patient safety and convenience. HCM patient satisfaction with

virtual consultations would be a further area to examine in relation to this.

Conflict of Interest None

24 PRIMARY AND SECONDARY ICD IMPLANTATION IN ADULT CONGENITAL HEART DISEASE PATIENTS FROM 2006 TO 2020: A SINGLE CENTRE EXPERIENCE

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10.1136/heartjnl-2021-BCS.24

Introduction Adults with congenital heart disease are at risk of developing sustained ventricular arrhythmias, due to the underlying structural heart disease, myocardial scarring from previous cardiac surgery, or failing systemic or subpulmonary ventricles. Therefore, there are a number of potential indications for ICD implantation, both primary and secondary. Here we describe the rates of ICD implantation over the last 15 years in adults with congenital heart disease in our centre.

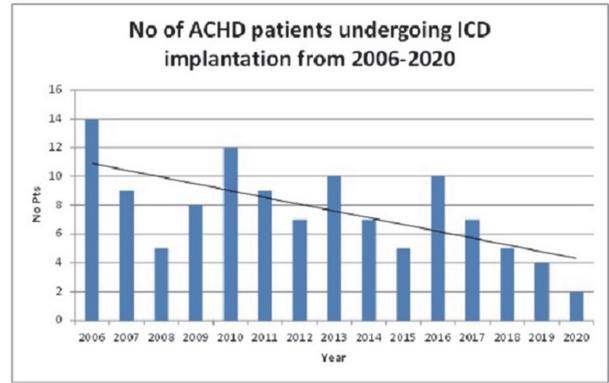
Methods A local database of all patients with congenital heart disease having undergone ICD implantation was interrogated to determine details of patients with new ICD implants from the last 15 years. Information on demographics, date of initial corrective cardiac surgery, date of ICD implant and indication for ICD were obtained.

Results 113 patients were identified, of which 65 (58%) underwent primary prevention device implantation and 48 (42%) underwent secondary prevention device implantation. 41 patients undergoing ICD insertion were female (36%) and 72 were male (64%).

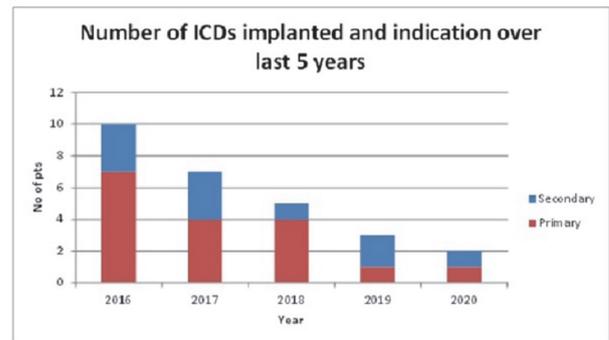
An overall downtrend in numbers of ICDs being implanted per year over the last 15 years was seen (figure 1A), the fall in the last 5 years being especially pronounced (figure 1B). There was a minor increase in the proportion of ICDs implanted for primary prevention in 2015 to 2020 (63%) compared to 2006 to 2015 (57%).

Time between initial corrective surgery and ICD implantation was similar through 2006 to 2020. Between 2006 and 2015 the average number of years between surgery and ICD implant was 27 years for primary prevention and 23 years for secondary. In the last 5 years the average number of years

Graph 1A

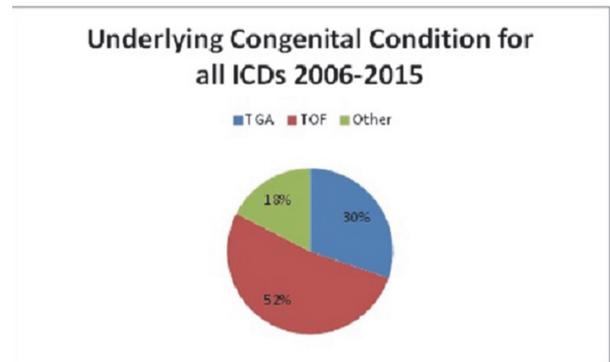


Graph 1B

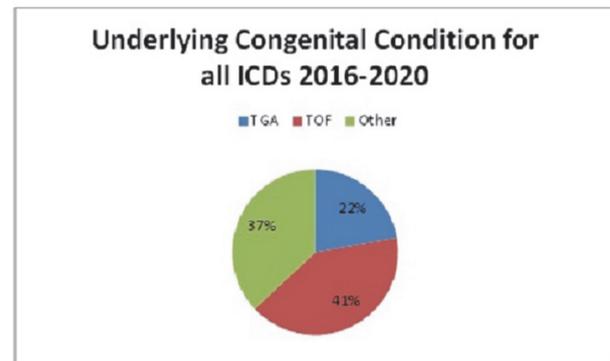


Abstract 24 Figure 1

Graph 2A



Graph 2B



Abstract 24 Figure 2

Abstract 24 Table 1 Adults undergoing ICD implants in 'Other' Category between 2006 and 2015

2006-2015		
Congenital Condition	No of Pts	Primary or Secondary ICD
Ebstein's	2	Primary (1) Secondary (1)
AVSD	2	Primary (2)
Dextrocardia PS VSD ASD PDA	1	Secondary
PS	2	Secondary (2)
ASD	2	Secondary (2)
Anomalous coronary artery	2	Secondary (2)
Coarctation and bicuspid aortic valve	1	Primary
VSD	3	Primary (2) Secondary (1)