was performed in 98% (405 lesions). Bailout stenting (with a drug eluting stent) was required in 7% lesions (n=30) and of which 11 were due to dissections and 19 were due to recoil >50% following DCB use. The mean diameter and length of DCBs were 2.47 mm and 26 mm respectively. During a median follow-up of 322-days (11-months) cardiac death was reported in 8 patients (2.3%). Target vessel MI was in 3%; n=10, TLR and TVR per lesion were 8% (n=34) and 9% (n=37) respectively. The MACE rate was 11%. There were no documented cases of acute vessel closure.

Conclusion The mid-term outcome from the first ever study on sirolimus coated balloons in de novo lesions appears promising with low rates of hard endpoints with no documented case of acute vessel closure. The MACE rates appear to support the efficacy of SCBs in de novo lesions. However, we need longer follow-up which is on-going, and we will be able to report outcomes from even longer follow-up during the presentation.

Conflict of Interest None to declare

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LEFT MAIN STEM PERCUTANEOUS CORONARY INTERVENTION IN A NON-SURGICAL CENTRE – A SAFE AND EFFECTIVE TREATMENT OPTION

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Introduction The ESC/EACTS 2018 guidelines on myocardial revascularisation supported the use of percutaneous coronary intervention (PCI) and coronary artery bypass grafting (CABG) for left main stem (LMS) disease of low complexity, and recommended CABG over PCI in disease of intermediate or high complexity. Following revelations of EXCEL study data, the guidance is being reviewed. Meanwhile, patients with LMS disease continue to present in both elective and acute settings, and clinicians face complex decision-making, which can be particularly challenging in non-surgical centres.

Methods The aim of this study was to investigate the safety and efficacy of LMS PCI in our non-surgical, 24/7 primary PCI centre. We have performed a retrospective analysis of 136 patients who underwent LMS PCI between 2015-2019 in both elective and acute (Non ST elevation-ACS and ST elevation MI) settings. The median follow up time was 19 months (range 12-59 months). Inpatient mortality and complication rates and all-cause mortality over the follow up period were assessed. We also examined use of the MDT and intracoronary imaging rates.

Results The number of PCI for LMS in both elective and acute settings steadily increased over the study period (figure 1). The patient and procedural characteristics are presented in tables 1 and 2, demonstrating appropriate patient selection (low risk anatomy, low percentage diabetes, predominant single stent strategy) and significantly increasing use of intracoronary imaging over time (figure 2). There was documented evidence of formal MDT discussion, or informal discussion with colleagues and the patient, in 82.1% of elective cases. In elective patients there were no in-hospital complications. In the acute cohort, we observed 2 post-procedural acute renal failure episodes, 1 embolic stroke and 1 episode of anaemia requiring blood transfusion. Overall, all-cause mortality at a median 19 months was 15.5% (21 of 136 patients). There

were 4 deaths among elective patients and 17 in ACS patients. Higher death rate in the acute cohort was partly driven by cardiogenic shock in STEMI patients. 8 patients required further PCI for in-stent restenosis.

Conclusions In an all-comer population, including those with cardiogenic shock, LMS PCI seems to be effective with

Abstract 65 Figure 1 Number of LMS-PCI performed between 2015–2019

Abstract 65 Figure 2 Proportion of cases optimised by intracoronary imaging in LMS-PCI by year

Abstract 65 Table 1 Patient characteristics

	Elective	Acute
Number of patients, n	56	80
Age, median (range)	71.5 (53-87)	70.5 (22-91)
Sex (male) n, (%)	43 (77.7)	49 (61.3)
Diabetes, n (%)	12 (21.4)	14 (17.5)
In-patient complications n, (%)	0	4 (5)
In-patient mortality, n (%)	0	5 (6.25)
All-cause mortality, n (%) at median 19 months	4 (7.1)	17 (21.3) – 6 NSTEMI, 11 STEMI
In-stent restenosis, n (%)	3 (5.4)	5 (6.25)
Documented formal/informal MDT, n (%)	46 (82.1)	44 (55)

Abstract 65 Table 2 Procedural characteristics

	Elective	Acute
Disease anatomy*		
- Ostial LMS n (%)	- 11 (19.6)	- 14 (17.5)
- LMS body n (%)	- 15 (26.8)	- 17 (21.3)
- Bifurcation n (%)	- 36 (64.3)	- 56 (70)
- Prox LAD/Cx n (%)	- 14 (25)	- 20 (25)
PCI technique, n (%)		
- Single stent	- 47 (83.9)	- 53 (66.3)
- Two-stent	- 9 (16.1)	- 27 (33.7)
Optimisation with intracoronary imaging, n (%)	42 (75)	36 (45)

acceptable mortality risk. In the elective setting, shared decision making via MDT is commonplace, appropriate patients are selected, acute complications are rare, and long-term outcomes are favourable with low in-stent restenosis rates. The acute setting, by default associated with a more adverse prognosis, presents more challenge – opportunity for MDT discussion is limited and patient/procedural factors can reduce intracoronary imaging rates. Procedural outcomes are favourable but all-cause mortality in LMS STEMI patients is predictably high. Finally, shared decision making is of paramount importance in this uncertain area and a further update to the guidelines will be welcomed.

Conflict of Interest none

66 A SURVEY OF CURRENT LEARNING METHODS USED BY INTERVENTIONAL CARDIOLOGY TRAINEES IN THE UNITED KINGDOM

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Introduction Interventional Cardiology is a specialism using minimally invasive catheter-based interventions for cardiac treatment, and therefore is largely procedure-based. Trainees enter sub-specialty training at beginner or intermediate level, and by completion of two years of sub-specialty training they are expected to be expert and independent in basic coronary angiography, simple angioplasty and stenting, pericardiocentesis and to be intermediate level in more complex procedures such as revascularisation of complete total occlusions. Sub-specialty training is usually a two-year programme based at one or more training hospitals. There is a curriculum and set of competencies which must be achieved, and this is assessed continually throughout the year and appraised annually (GMC, 2018). Aim The aim of this research was to understand the learning methods experienced by Interventional Cardiology trainees in the United Kingdom and explore the value of these methods as perceived by trainees.

Methods Taking a pragmatist learning approach within the framework of critical theory, a quantitative survey was conducted. Trainees were approached via social media networks, local mailing lists and directly via Training Programme Directors where possible. The survey was delivered and analysed through Google Forms. Ethical approval was obtained from the University of Dundee.

Results Thirty-four interventional trainees (ST5 level and above) in the United Kingdom responded to the survey. Catheter laboratory training sessions and case based discussions were considered the most useful learning methods. Over half of respondents reported that their learning would be enhanced if they had greater opportunity to utilise catheter laboratory training sessions, case-based discussion and simulation. Over one third are planning or have completed an out of training fellowship abroad, and nearly a third are planning of have completed an out of training fellowship in the UK or abroad. Nearly a half of respondents reported they would like to training coronary, structural and complex coronary intervention, whilst 27% said they would like to train in coronary and structural intervention, and 29% said they would like to training in coronary and complex coronary intervention. Over one third of respondents said they would additional further

training in other sub-specialties (most commonly devices and imaging).

Conclusion We report our findings on learning methods utilised by Interventional Cardiology trainees and in the UK, as well as findings on trainee preferences for the future direction of training.

Conflict of Interest None

67 YOUNG PATIENTS WITH NON-ST ELEVATION ACUTE CORONARY SYNDROMES: BASELINE CHARACTERISTICS, IN-HOSPITAL MANAGEMENT AND OUTCOMES

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Background There is an alarming increase in prevalence of acute coronary syndromes in young population, yet, there is limited data about the in-hospital management strategy and outcomes in this population. Furthermore, up to our knowledge, there is no data from Iraq regarding clinical profile and in-hospital management of young patients with NSTEMI-ACS.

Purpose We aimed to assess the clinical profile, in-hospital management and outcomes of hospitalized young patients whose age ≤ 50 years who were presented with NSTEMI-ACS.

Methods This study included admitted patients with NSTEMI-ACS whose age ≤ 50 years, baseline characteristics and in-hospital management as well as outcomes were recorded.

Results Total n.=280, 80 patients were excluded from analysis due to missing some of data, 23% of included patients were at age ≤ 50 years, among whom 84.8% were males vs 15.2% females. Mean age of young patients was 43.6 ± 6.3 years. Of this young patient population: hypertension, diabetes and prior history of IHD reported in 52.2%, 43.5% and 32.6% respectively while smoking, hyperlipidemia and positive family history of IHD were reported in 56.5%, 19.6% and 34.8% respectively. Dyspnea at presentation was reported in 19.6%, troponin was positive in 43.5%, mean urea was 31.6 ± 16 mg/dl, mean creatinine was 0.86 ± 0.33 mg/dl, mean Hb was 14.2 ± 1.7 gm/L, their mean left ventricular EF% was 57.4 ± 10.4 . Young patients were referred for catheterization in 84.8%, however, at high GRACE risk class; they were treated invasively less than young patients at low

Abstract 67 Figure 1