smoking (87.1%) and a healthy diet (46.5%) were the most common healthy behaviours. Table 1 demonstrates each LS7 frequency in the population. The only statistically significant correlation was a higher BNP level with a lower BMI (P<0.05) (figure 2a). The other LS7 behaviours (diet, PA, smoking status, blood pressure, glucose and cholesterol (figure 2b-g)) as well as a composite (figure 2h) demonstrated no significant correlation with BNP.

Conclusion Analysis shows that LS7 scores vary widely in those at risk for HF. The areas of prime concern are lack of adherence to physical activity, blood pressure control and maintaining a healthy weight. The failure to show an association between LS7 and BNP might reflect the divergent impact of components of this score on BNP. For example, increasing BMI with reduction in BNP and poor BP score with increasing BNP. This analysis provides two important pieces of information in our effort to provide an overarching approach to HF prevention, firstly, the need to place an emphasis on BP management and a healthy weight but also to target physical activity levels. Secondly, the lack of association between BNP and LS7 score indicates that while BNP remains the ultimate risk indicator, that it does not appear to reflect this aspect of care.
yield. It was observed that a large percentage of hs-cTn were ordered inappropriately. Out of the total (n=124), 56% (n=70) requests were appropriate and 44% (n=54) were inappropriate. In the ED setting, most of the requests were ordered as part of routine bloods during triage. We identified areas where interventions could be made for quality improvement. We highlighted the findings of our audit to the Triage nurses and ED medical staff. A poster of local hospital guidelines was hung in Triage rooms, routine testing of hs-cTn before clinician assessment was discouraged, and it was suggested that a hs-cTn could be easily added on after clinical assessment.

We repeated the audit after 1-2 months using the same methods during data collection. After PDSA cycle 2 (n=155), 74% (n=114) requests were appropriately sent and 26% (n=41) were inappropriate. Following Cycle 2, we re-educated and stressed the importance of following hs-cTn guidelines. Finally, we performed a third cycle over 2 weeks analysing hs-cTn ordering and indications. In PDSA cycle 3 (n=118), 70% (n=83) of the requests were appropriate and 30% (n=35) were inappropriate. A quantifiable improvement was noted on repeat audit cycles with a further potential of reducing inappropriate requests.

Hs-cTn is a gold standard test in diagnosing Acute Coronary Syndrome (ACS). However, one has to be aware of the varying clinical circumstances in which it can be elevated. Hs-cTn testing is only indicated when ACS is clinically suspected. Appropriate use of ESC and local guidelines with hs-cTn requests can lead to a significant reduction in admissions, workload and financial burden.

LONG-TERM CLINICAL OUTCOMES AFTER DRUG ELUTING STENT IMPLANTATION WITH AND WITHOUT STENT OVERLAP

Aims The aim of this study was to investigate the impact of drug eluting stent (DES) overlap on clinical outcomes after percutaneous coronary intervention (PCI).

Methods We analyzed the angiographic and clinical outcomes of 5,605 patients treated with DES in the setting of the ISAR-TEST 4 and ISAR-TEST 5 trials according to the presence or absence of stent overlap at index PCI. The 10 year clinical endpoints assessed were all-cause death, myocardial