(28 patients, 57.14%) [table 1]. The co-primary endpoint of successful implantation of the LAA occlusion device occurred in 24 patients (96%) in the ICE group compared to 24 patients (100%) in TOE guided LAAO group (96% vs. 100%, $P=1.00$). There were no incidences of procedure

Abstract 57 Figure 1 (Left to Right): IA Fluoroscopic Image Showing ICE Catheter (Circled) On Left. IB: ICE Catheter on Left, Amplatzer Delivery Sheath On Right Deploying Amulet LAAO Device. IC Contrast Image Post Deployment of LAAO Device Showing No Opacification of Left Atrial Appendage with Contrast, Indicative of Satisfactory Occlusion of LAA

Abstract 57 Table 1 Baseline patient characteristics

	ICE Guided (n=25)	TOE Guided (n=24)
Age	76 ± 6.07	78.58 ± 6.63
Sex M(%) / F(%)	18(72%) / 7(28%)	19(79%) / 5(21%)
CHA ₂ DS ₂ -VASc	3.84 ± 1.08	3.75 ± 0.92
HASBLED	2.96 ± 0.72	2.875 ± 0.88
Baseline Haemoglobin	12.53 ± 1.69	13.175 ± 1.48
Baseline Creatinine	91.72 ± 22.21	100.5 ± 28.57
Indication for LAA occlusion:		
-Intracranial Haemorrhage (%)	9(36%)	3 (12.5%)
-GI Bleeding (%)	13 (52%)	15 (62.5%)
-Epistaxis (%)	1 (4%)	1 (4.2%)
-Stroke on NOAC Therapy (%)	1 (4%)	0 (0%)
-Haematuria (%)	1 (4%)	2 (8.4%)
-Other (%)	0 (0%)	3 (12.5%)

± Values Refer to Standard Deviation from the Mean Value.

Abstract 57 Table 2 Primary and second endpoints

	ICE Guided (n=25)	TOE Guided (n=24)	P Value*
Primary Endpoints:			
Successful Implantation (%)	24 (96%)	24 (100%)	0.312
Procedure Related Death (%)	0 (0%)	0 (0%)	N/A
Secondary Endpoints:			
Fluoroscopy Time (Mins)	41.64 ± 13.39	63.08 ± 14.93	<0.001
Procedure Time (Mins)	127.56 ± 49.32	184.92 ± 63.16	<0.001
Haematoma (%)	0 (0%)	2 (8.33%)	0.235
LOS	2.6 ± 1.55	2.92 ± 1.15	0.03
Cardiac Arrest (%)	0 (0%)	1 (4.16%)	1.00
Pericardial Effusion (%)	1 (4%)	1 (4.16%)	1.00
Tamponade (%)	1 (4%)	0 (0%)	1.00
Peri-Device Leak (%)	1 (4%)	1 (4.16%)	1.00
Device Embolisation (%)	0 (0%)	1 (4.16%)	0.490

± Values Refer to Standard Deviation from the Mean.

*P Value from Mann Whitney U Test/Fishers Exact/T-Test as detailed in methods.

*P Value <0.05 was determined to be statistically significant.

related mortality in either group. Mean fluoroscopy time was shorter in the ICE group than the TOE group (Mean (SD)=41.64 (13.39) vs Mean (SD)=63.08 (14.93); 95% confidence interval (CI) 13.30 to 29.59; $P<0.001$). Mean procedure time was also shorter in the ICE group; (Mean (SD)=127.56 (49.32) vs Mean (SD)=184.92 (63.16); 95% CI 24.86 to 89.85; $P<0.001$). Mean hospital length of stay was lower in the ICE group (2.6 days (SD=1.55) vs. 2.92 (SD=1.15); 95% Confidence Interval (CI) 2.36 to 3.18; $P=0.025$). There were no statistically significant differences between the groups with regards to the other secondary endpoints [table 2].

Conclusion ICE guided LAA occlusion leads to shorter hospital length of stay, procedure time and reduces time spent under fluoroscopy compared with TOE guided LAA occlusion. There was no statistically significant variations in the procedural complications between the two groups. ICE guided LAA occlusion removes the need for GA, making procedures logistically less challenging and eliminating the need for an aerosol generating procedure (TOE). In the current climate of a global Covid-19 pandemic which has limited access to ICU beds and anaesthetic support, ICE guided LAAO is a safe and cost effective alternative for stroke prevention to TOE guided LAAO in patients with high CHA₂DS₂-VASc scores and contraindications to oral anticoagulation. We will continue to follow these patients with gated CT Aorta to ascertain the incidence of device leak.

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IMPROVING EFFICACY AND SUSTAINABILITY OF VIRTUAL CARDIOLOGY CLINICS

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Introduction Social distancing measures were introduced in Ireland to address COVID-19 in March 2020. Strategies to continue Cardiology outpatient services needed to balance patient safety with the need for high quality follow-up care. Therefore, virtual consultations (via phone or video call) were implemented as temporary alternatives to in-person clinics.

Objectives and Methodology We aimed to identify inefficiencies in physical outpatient services at Beaumont Hospital in comparison with virtual consultations. In face-to-face visits, a patient's average time outside the physician's examination room was 39 minutes (range 12-110 minutes). Increased delays occurred if investigations were awaited. The average face-to-face consultation lasted 24 minutes. Next, an analysis was performed on 100 consecutive patients' virtual consultation experiences. Electronic survey responses were collected from stakeholders including patients, physicians, nurses, and clerical staff relating to these virtual visits.

Results 81% of outpatient consultations were delivered virtually from July to December 2021, with an average duration of 19 minutes. Patient volume was increased (5 additional patients per week per clinic) with a reduced waiting time for routine attendance. Criteria for outpatient re-attendance was regularly reviewed, with discharge facilitated at the second or third visit if clinically indicated. 89% of visits were supported by communications technology (smartphone or internet access)