Introduction Hypertrophic cardiomyopathy (HCM) is a heart muscle disease with few targeted therapies. Patients with left ventricular outflow tract obstruction (HOCM) are at risk of sudden cardiac death and may experience symptoms of dyspnoea, fatigue, dizziness and palpitations. As a result, the burden of symptoms often has a significantly detrimental effect on activities of daily living, exercise tolerance and subsequently results in a reduction in quality of life. HOCM patients have been treated historically with limited medical therapy options (beta-blockers and/or calcium channel blockers or Disopyramide) before proceeding to high-risk invasive treatments (alcohol septal ablation or myomectomy). There is a substantial unmet need in HCM for specific treatments to reduce obstruction and improve other parameters of left ventricular function. Mavacamten, a first-in-class, small molecule, selective allosteric inhibitor of cardiac myosin ATPase, is a new treatment for HOCM, but not routinely available in the UK pending marketing authorisation expected in Q4 2022.

Methods In anticipation of a dedicated Inherited Cardiac Conditions service for the Essex region, patients attending a general cardiology clinic with HCM were screened, to determine potential eligibility for Mavacamten. Criteria described in the double-blind, randomised multicentre Phase 3 EXPLORER-HCM study were analysed: symptomatic New York Heart Association (NYHA) class II and III; LVEF >55%; and Left Ventricular Outflow Tract (LVOT) peak gradient >50 mmHg at rest or with provocation.

Results A total of 92 HCM patients were identified, with median follow up period 52 months, median age 56 years (range 15–86), and male sex in 64%. Twelve patients had an implantable cardioverter defibrillator (ICD, 13%), 3 patients had a dual chamber pacemaker (3%) and 1 patient underwent surgical myomectomy. Maximum wall thickness (MWT) ranged from 1.2cm to 3.3cm with median LVOT gradient 9 mmHg (IQR 5–21, maximum 135 mmHg). Thirteen patients (14%) met eligibility criteria for Mavacamten and of these 62% were on a beta-blocker and 15% were on Disopyramide. Mavacamten eligible HCM patients were of similar age to ineligible patients (median 56 years for both groups, p = 0.862), with similar wall thickness (median 1.7cm for both groups, p = 0.373) and LVEF (67% vs 66%, p = 0.471), but had significantly higher LVOT gradient (median 71 mmHg vs 7 mmHg, p <0.001) and worse symptoms (92% vs 34% NYHA class 2/3, p = 0.034). Despite this, there was similar survival (p = 0.57), with a trend towards better survival in Mavacamten eligible patients compared to Mavacamten ineligible patients under proposed criteria (Figure 1).

Conclusion Treatment options for HCM are limited; the cardiac myosin inhibitor Mavacamten is an exciting new therapy, but it is currently unavailable in the UK. A small minority of our HCM patients meet the proposed criteria for Mavacamten, and within our cohort these patients do not have significantly reduced survival on current therapy. Given the mechanism of action of Mavacamten, further studies in all HCM patients, with or without obstructive physiology, are needed to expand potential licensing indications.

Conflict of Interest Nil

32 MAVACAMTEN ELIGIBILITY IN PATIENTS WITH HYPERTROPHIC CARDIOMYOPATHY ATTENDING CARDIOLOGY CLINIC IN ESSEX, UK

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Objective To explore the value of thoracoscopic pericardial fenestration in the diagnosis and treatment of tuberculous pericardial effusion.

Methods 33 patients with unexplained massive pericardial effusion underwent thoracoscopic pericardial fenestration.

Abstract 33 Table 1 Modified World Health Organization classification of maternal cardiovascular risk

<table>
<thead>
<tr>
<th>Category</th>
<th>Maternal cardiac event rate</th>
<th>Recommended Location of Care During Pregnancy and Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>mWHO I</td>
<td>2.5-5%</td>
<td>Local Hospital</td>
</tr>
<tr>
<td>mWHO II</td>
<td>5.7-10.5%</td>
<td>Local hospital/Referral hospital</td>
</tr>
<tr>
<td>mWHO III</td>
<td>19-27%</td>
<td>Expert centre for pregnancy and cardiac disease</td>
</tr>
<tr>
<td>mWHO IV</td>
<td>40-100%</td>
<td>Expert centre for pregnancy and cardiac disease</td>
</tr>
</tbody>
</table>

Abstract 33 Figure 1 Breakdown of patients seen in the combined obstetrics-cardiology clinic by diagnosis
Abstract 33 Figure 2. Breakdown of mWHO classification of patients seen in the combined obstetrics-cardiology clinic by diagnosis

Results 14 cases were diagnosed as tuberculous pericarditis by pericardial biopsy. There were no complications during and after operation. The thoracic drainage tube was pulled out 24 – 85 hours after operation (average 33.5 hours). During the follow-up, there was no recurrence of pericardial effusion and no constrictive pericarditis.

Conclusion Thorascopic pericardial fenestration is a safe and effective method, which can be used as a diagnosis and treatment method for a large number of pericardial effusion of unknown cause.

Conflict of Interest NO

34 UTILISATION OF A COMBINED OBSTETRIC-CARDIOLOGY CLINIC IN A UK TERTIARY CARDIOLOGY CENTRE

Introduction Cardiac disease remains the leading cause of indirect maternal death in the UK, of which mortality rates from cardiac disease has remained unchanged at approximately 2 per 100,000 maternities over the last two decades. Cardiac disease also accounts for 12% of all cause mortality in the postpartum period. The 2018 ESC Taskforce guidelines has since introduced the concept of the pregnancy heart team to further optimize and tailor the management of women at moderate to high cardiovascular risk based on their modified WHO (mWHO) risk classification (Table 1). We evaluated how this service was utilised in a tertiary hospital in its first year of inception.

Methods All patients that were referred to the combined obstetric-cardiology clinic between November 2020 and November 2021 were included. Data including demographics, underlying cardiac diagnosis, mWHO risk classification, cardiac investigation findings (if performed) and whether pre-conception counselling or delivery recommendations were made during these consultations were collected from clinic letters and from the local electronic database. Results 73 patients were referred to the combined obstetrics and cardiology clinic, of which 66 were seen, 4 did not attend and 3 did not have a documented clinic letter. Of the 66 seen, the mean gestational age at first presentation was 22.6 weeks. 15 (22.7%) had an underlying inherited cardiac condition, 13 (19.7%) had arrhythmia, 7 (10.6%) had valve disease, 8 (12.1%) had cardiomyopathy and 23 (34.8%) had other cardiac diagnosis (aortic disease, simple shunts and palpitations/syncope with no documented arrhythmia) (Figure 1). Among these patients, 22 (33.3%) had mWHO I, 35 (53%) had mWHO II, 7 (10.6%) had mWHO III and 2 (3%) had mWHO IV (Figure 2). Only 6 of the 66 patients had pre-counselling advice documented, all had delivery recommendations made following the consultation.

Conclusion A combined obstetric cardiology clinic was an unmet need at this tertiary hospital and uptake has been good in the first year since its inception. Future work will however be required to promote preconception counselling as well as to develop formal guidelines and referral pathways to further optimize utilisation of this pregnancy heart team clinic.

Conflict of Interest None

35 RAISING THE SUSPICION OF ADULT CONGENITAL HEART DISEASE (ACHD) IN SYMPTOMATIC PATIENTS WITHOUT ABNORMAL INITIAL ECHOCARDIOGRAPHIC FINDINGS: A CASE REPORT

Introduction Patients with adult congenital heart disease (ACHD) often initially present to their local hospital with cardiovascular symptoms such as dyspnoea and palpitations. Most patients undergo an echocardiogram as part of their initial investigations for more common aetiologies such as valvular heart disease, arrhythmias, and cardiomyopathies. The possibility of ACHD is often to the causes above therefore despite a systematic segmental approach, it is often not thoroughly considered when performing the initial echocardiogram. This can delay diagnosis and management. We report a case of a missed PDA in a 71-year-old female presenting with shortness of breath and palpitations for 10 years.

Methods A 71-year-old female with no significant medical history presented with shortness of breath and palpitations. She had had these symptoms for over 10 years. Method A 71-year-old female with no significant medical history presented with shortness of breath and palpitations. She had had these symptoms for over 10 years. On initial presentation at the age of 61. She had previously been investigated with an echocardiogram which was unremarkable (see results) as well as no evidence of arrhythmia on Holter monitoring. Her thyroid function and electrolytes were all unremarkable. On re-review, we subsequently repeated the echocardiogram and Holter monitor in view of worsening palpitations. We compared the images obtained on the echocardiograms to identify any discrepancies.

Results Echo in 2013: Non dilated LV with good systolic function, grade 2 diastolic dysfunction, mildly thickened aortic valve with mild AR. LVEDV 102 ml, LAEDV 117.05 ml, LV mass 117.05 ml/m2.10filtration at onset. PDAs usually close spontaneously within 24–48 hours after birth and are rarely encountered in adulthood, often found incidentally.

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