



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 Thoracoscopic 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

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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 100,00 maternities over the last two decades. Cardiac disease also accounts for 12% of all-cause mortality in the post-partum 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

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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. 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 with the 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 thicken aortic valve with mild AR. LVEDV 102 ml, poor image quality for LAVI measurements. Echo 2021 (Figure 1): Normal LV size, wall thickness and systolic function. Left atrium dilated, moderate AR and aortic root dilatation. Patent ductus arteriosus. LVEDV 117.05 ml, LAEDVInd 54.44 ml/m² ECG 2021: AF (Figure 2) Discussion Patent ductus arteriosus (PDA) represents a communication between the aorta and the pulmonary artery with a left-right shunt at onset. PDAs usually close spontaneously within 24–48 hours after birth and are rarely encountered in adulthood, often found incidentally.