further ischaemic symptoms, and no arrhythmias were deemed suitable for early discharge. All patients were given a blood pressure machine to take home and advised to check their blood pressure regularly. Follow-up was arranged in the form of a 48 h phone call and video consultations with a prescribing Advanced Nurse Practitioner at 2 and 8 weeks post-discharge.

Results During the study period, 21 patients were discharged on the early discharge pathway. The average length of inpatient stay was 35.9 hours. This was significantly less than the average inpatient stay of 79.3 hours for matched low-risk patients before introduction of the pathway. No major adverse events (death, re-infarction, or need for further revascularisation) were reported during the initial follow-up period. All patients had their blood pressure control and medications reviewed during the follow-up consultations. 61.9% of patients had their secondary prevention medications (ACEI or beta-blockers) uptitrated after the 2-week appointment. 77.7% patients had their medications uptitrated after the 8-week appointment. A patient satisfaction survey was carried out after the 8 week follow-up. The responses were overwhelmingly positive with a reduction in patients re-presenting to acute services.

Conclusion From our experience, selected low-risk patients can be safely discharged 24 hours after successful primary PCI. This results in significantly reduced inpatient stay, improved patient experience and increased bed capacity on coronary care units. It is, however, essential to have an enhanced follow-up plan in place with prescribing nurse practitioners to address any early issues.

Conflict of Interest None

55 USE OF SIROLIMUS COATED BALLOON IN DE NOVO SMALL VESSEL CORONARY LESIONS IN ACUTE CORONARY SYNDROME; LONG-TERM FOLLOW-UP FROM A SINGLE CENTRE REGISTRY

Maria Zakai, Bhagya Hairidi Loku Waduge, Nilin Kumar, Jerome Ment, Bethan Freestone, Michael Pitt, Gurbir Bhata, Sampath Athukorala, Kaeng Lee, George Pullikal, Sandeep Basavangud, Heartlands Hospital, Bordesley Green East, Birmingham, WMID 89 SS, United Kingdom; Heartlands Hospital, Birmingham, WMID 89 SS, United Kingdom; Heartlands Hospital, Birmingham, WMID 89 SS, United Kingdom

Background Drug coated balloons (DCBs) are mainly used in restenotic lesions as endorsed by the European Society of Cardiology, with a class IA recommendation. However, some of the recent data suggest, it can also be considered in a subset of denovo lesions. In this study, we report outcomes from the use of a Sirolimus coated balloon (SCB) in de novo small-vessel coronary lesions specifically in the context of acute coronary syndrome (ACS), from a high volume centre.

Methods A retrospective analysis was conducted on all patients treated with an SCB for de novo small vessel lesion in ACS, of which 20% were STEMs (n = 59) with the remainder being NSTEMIs (n = 230) and there were 319 NSTEMI lesions and 82 STEMI lesions treated. The mean age of patients was 65 years (range 37–97), 81 (55%) were male, 41% (n=119) had diabetes, 73% (n= 210) had hypertension and 21% (n=59) had chronic kidney disease. Pre-dilatation was performed in 98% lesions (n = 394) and bailout stenting (with DES) was required in 3.2% of lesions (n=13). The mean diameter and length of DCBs were 2.78 mm and 26 mm respectively. During a median follow-up 570 days (19 months), cardiac death was reported in 8 patients (3%). Target vessel MI was in 7% (n=19), TLR per lesion was 12% (n=48) and the MACE rate was 14% (n=41). There were no documented cases of acute vessel closure.

Conclusion The long-term outcome from the first ever study on sirolimus eluting balloon in de novo small vessel lesions in ACS appears promising with low rates of hard endpoints and acceptable TLR. This study suggests that use of SCB in de novo small vessel lesions in ACS may be reasonable therapeutic option.

Conflict of Interest None

56 CAN WAITING TIMES FOR URGENT CABG BE REDUCED TO FALL WITHIN NATIONAL RECOMMENDATIONS? INSIGHTS FROM A LARGE TERTIARY CARDIAC CENTER

Ahmed Elamin, Esam Muhammed, Hasan Ahmad, Asad Bhatti, Clare Appleby, Liverpool Heart and Chest Hospital, Thomas Drive, Liverpool, MSY L14 3PE, United Kingdom; Liverpool Heart and Chest Hospital

Introduction Prolonged waiting times for urgent Coronary Artery Bypass Graft (CABG) are associated with adverse outcomes. Historically, analysis of inpatient CABG at Liverpool Heart and Chest Hospital (LHCH) between 11/2016–1/2017 identified a 10-day median time from referral to operation (interquartile range: 7–14). In an attempt to achieve the national 7 day target, the trust introduced changes to working patterns for surgical consultants including a surgeon of the week (SOW), and daily multidisciplinary team meetings (MDM). To evaluate the effect of these changes on achieving target, a further analysis was undertaken.

Methods LHCH is a stand alone cardiothoracic centre: referrals are direct from 7 partner hospitals (19%), or internally from cardiology team (81%). Retrospective data were collected for all patients who had non-elective CABG (excluding valve and aortic surgery) during two specified periods July-September 2019, April-July 2020. Data were extracted from electronic patient records, manually reviewed and crosschecked to ensure accuracy.

Results Between July-September 2019, the median time from referral to operation for 109 eligible patients was 7 days (interquartile range: 6–9). 60% underwent CABG within 7 days for the group referred from LHCH directly, and only 25% had their operation within 7 days for the group referred from other trusts. Between April-July 2020, 54 eligible patients were included. The median waiting time was 8 days (interquartile range: 6–10). 42% underwent CABG within 7 days for the group referred from LHCH directly. Similar trend observed in the group referred from other trusts with only 33% had their operation within 7 days. The distributions of waiting times were not significantly different between these two time periods (Mann-Whitney U test p-value 0.12), but there was a significant improvement compared to the 2016-17 cohort, where only 25% referred from LHCH, and 18% referred from other trusts had their CABG within 7 days.