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% of 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

### Abstracts

**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**

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**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 de novo 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 ACS between March 2018 and October 2020. Follow-up was achieved with clinic visits, telephone calls and admission records. The outcomes measured include cardiac death, target-vessel myocardial-infarction, target lesion revascularisation and MACE (combination of cardiac death, target-vessel MI and TLR).

**Results** During the study period, 289 patients (401 lesions) were treated with an SCB for de novo small vessel lesion in ACS, of which 20% were STEMI (n=59) with the remainder being NSTEMI (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
Abstract 56 Table 1 Detailed breakdown of CABG waiting times (median days) for patients during different study periods

<table>
<thead>
<tr>
<th>Time period</th>
<th>Original admission to operation (Days)</th>
<th>Original admission to referral (Days)</th>
<th>Referral to operation (Days)</th>
<th>Referral to surgical review (Days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2016 – January 2017</td>
<td>13</td>
<td>3</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>July 2019 – September 2019</td>
<td>11</td>
<td>3</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>April 2020 – June 2020</td>
<td>11</td>
<td>2</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

Abstract 56 Figure 1 Causes of long CABG waiting times between July 2019 – September 2019.

Abstract 56 Figure 2 Causes of long CABG waiting times between April 2020 – June 2020.

Conclusions Median waiting times for urgent CABG I significantly improved by implementing the SOW work pattern and daily MDMs. Despite this, 40% percent still fail to have surgery within the recommended 7 days. This reflects a national picture, highlighted by the national audit of adult cardiac surgery (NACSA) and suggests that further improvements will require substantial resources.

Conflict of Interest None

57 REAL WORLD OUTCOMES OF IFR GUIDED PCI IN A SINGLE CENTRE

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Introduction Large, randomized studies have shown that resting indexes (derived from the pressure measurement at rest without the administration of adenosine, iFR) have diagnostic accuracy similar to that of FFR as independent measures of ischemia. Our study was to assess real world outcomes at 12 months following iFR Guided PCI at East Lancashire Hospitals NHS Trust.

Methods This was a retrospective observational study which included adult patients ≥18 years who underwent angiography with iFR performed at the discretion of the operator over a 12-month period, from 1 January 2018 to 31 December 2018. Data were collected on baseline characteristics, indication, target vessels, binary iFR result (positive ≤ 0.89 vs negative > 0.89) and final treatment. The primary outcome was major adverse cardiac events at 12 months follow up.

Results In total 136 patients (75% male) underwent a total of 137 procedures. The majority (85%) of patients had ≥2 cardiovascular risk factors, with stable angina the commonest indication (50%). iFRs were performed in 226 vessels of which 113 (50%) were positive and treated by stenting (n=70, 61.9%), CABG (n=24, 21.2%), balloon angioplasty (n=3, 2.7%) and no treatment (n=16, 14.2%). None of the iFR negative lesions (n = 113) had any intervention or associated adverse outcomes during the follow up period. At 12 months, 8 major adverse cardiac events were recorded with 1 cardiovascular death due to the index event, 1 non-cardiovascular death, 4 unstable angina presentations due to de novo lesions and 2 cases of non-fatal MI due to de novo lesions and known iFR+ lesion, respectively.

Conclusion A negative iFR conferred an excellent event-free short-term outcome.

Conflict of Interest None

58 4-METRE-GAIT SPEED AS A PREDICTOR OF 5-YEAR SURVIVAL AFTER ACUTE MYOCARDIAL INFARCTION: A PROSPECTIVE COHORT STUDY

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Introduction Patients undergoing primary percutaneous coronary intervention (PPCI) for myocardial infarction (MI) are increasingly frail and multi-morbid and modelling patient outcomes is important with limited healthcare resource. Recognised parameters and scores predicting survival after PPCI can be complex. The 4-Metre Gait Speed (4MGS) is simple, quick, low-cost and requires little training. A gait speed of <0.8 m/s is associated with increased mortality, independent of age in the general population, and with higher cardiovascular events and readmission post-MI. We evaluated the 4MGS as a predictor of mortality following PPCI.Methods 560 patients, who had undergone PPCI from December 2013 – January 2016 and survived to discharge were recruited and divided into slow (<0.8 m/s) and fast (≥ 0.8 m/s) walkers according to 4MGS. Recognised predictors of mortality following PPCI including age, renal disease, diabetes and left ventricular ejection fraction (LVEF) were recorded. The primary and principle secondary outcome measures were the ability of the 4MGS at discharge after PPCI to predict all-cause mortality at 1 and 5-years respectively. Mortality traces using the NHS Demographic Batch Service were run at 1 and 5-years. Cox proportional hazards regression analyses were conducted for mortality outcomes at 1 and 5-years. Univariate analyses for recognised predictors of mortality were