revascularisation (TVR) and MACE (combination of cardiac death, target-vessel MI and target vessel revascularisation).

Results

30 patients with a mean age of 73 (range 56–90 years) were treated with PCI to SVG in context of ACS of which 30% were ST-segment elevation myocardial-infarction (n=9), 80% males (n= 24), 57% were diabetic (of those 71% were insulin dependent), 40% (n=10) had renal-dysfunction (GFR <60 ml/min) and 38% had impaired left ventricular function (ejection-fraction <50%). Based on the angiographic review, 30% (n=9) of grafts were considered degenerate (ectatic, aneurysmatic and/or thrombotic). During the procedure, the majority (86%) used semi-compliant balloons and 47% non-compliant balloons, thrombus aspiration was used in 17% cases and the use of GP IIb/IIIa inhibitors was 10%. Slow-flow/ no-flow occurred in 27% (n=8) of procedures necessitating use of intra-coronary vasodilator in 10% of cases (n=3) with overall success rate of 96% (n= 29). In 5 cases (16%), drug eluting balloon (DEB) was used, the others (84%) utilised stents (n=25). The average stent diameter was 3.4 mm and length was 25 mm and average DEB diameter was 3.4 mm and length was 31 mm. There were 2 deaths before discharge. During a median follow-up of 1400 days (46 months), cardiac death occurred in 9 patients (30%), target vessel MI was in 10% (n=3); TLR was 17% (n=5), TVR 17% (n=5) and overall MACE rate was 47% (n=14).

Conclusions

Our data suggest that the long-term outcomes following intervention to re-stenosis of SVG-PCI in ACS has an unacceptably high MACE rate in this small study group. Given this, maybe we should consider PCI to native circulation if there is such an option especially given the current improvement in complex PCI techniques.

Conflict of Interest

None

66 IMPACT OF USING THE PAPWORTH HAEMOSTATIC CHECKLIST ON CARDIAC SURGERY PATIENT OUTCOMES AT QUEEN ELIZABETH HOSPITAL BIRMINGHAM, UNITED KINGDOM

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Background

Mediastinal bleeding is a common, major complication of cardiac surgery. Treatment requires patients to return to theatre to identify the source of bleeding which is associated with significant mortality and immediate postoperative morbidity (notably acute renal failure, infection, and stroke) as well as the risks of allogeneic blood product use, mechanical ventilation and longer ICU stay.(1,2) The Papworth Haemostatic Checklist (PHC) is an effective tool to reduce postoperative mediastinal bleeding in cardiac surgery by systematically checking surgical sites and coagulation status before sternal wire insertion.(3–5) A pilot study showed significantly reduced rates of bleeding, re-exploration and blood product consumption in 5000 patients undergoing cardiac surgery over a 2-year period. The checklist’s success won a nomination for a national patient safety award. Aims and objectives: This quality improvement project (QIP) aims to improve patient outcomes at Queen Elizabeth Hospital Birmingham (QEH) by implementing the PHC.

Methods

We retrospectively extracted data from electronic health records for 150 patients undergoing cardiac surgery from Dec’20-Aug’21. Baseline demographics and postoperative outcomes (mediastinal blood loss, re-exploration and blood product transfusion) were analysed.(6)

Results

Median blood loss 12 h post-operation was 429.81 ml (IQR 243.75). 3.33% underwent reexploration for bleeding and 46.6% received blood products. Median ICU stay was 3 days (IQR 2) and 2% of patients died.

Conclusion

This first cycle of the QIP showed significant complications from bleeding in terms of patient outcomes and cost to QEH. Following discussion, the department decided to implement the checklist to improve this. Our next steps are to familiarise operating teams with the PHC through posters and staff briefings. The anaesthetics team will be responsible for going through the checklist during the operation. We will subsequently undertake a second cycle of data collection and analysis for a further 150 patients.

Conflict of Interest

None

67 SAFETY AND EFFICACY OF DRUG-COATED BALLOONS – A RETROSPECTIVE OBSERVATIONAL STUDY

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Background

Drug-coated balloons (DCB) are an increasingly important component in the interventionalist’s toolkit. Whilst now a class I recommendation for instant restenosis (ISR), their use in de novo coronary lesions and large vessels remains understudied. With evident limitations of stent implantation, including exaggerated neointimal growth and late stent restenosis, the need for further study into the safety and efficacy of DCBs for various indications remains paramount. AimsOur aim was to evaluate the use of DCB at our centre, including in de novo disease and large vessel size, patient characteristics and risk factors, efficacy, and complication rates. MethodsPatients treated with a DCB from March 2020 to September 2021 were included. Electronic notes and procedure reports were analysed. Information was collated related to patient demographics and cardiovascular risk factors, index procedure, indication, DCB type and size and complications including bail-out stenting, 30-day re-admission and target vessel and lesion revascularisation (TVR, TLR). Results61 patients were included: M:F 43:18, mean age 65 years (36–88). 59% of cases were emergencies, the remainder were elective. There was de novo coronary disease in the majority (44) whilst 15 cases had ISR and 2 had mixed disease. We used a Sirolimus-coated balloon in 39 cases (MagicTouch, Selution), Paclitaxel-coated (BioStream) in 18 and a combination in 4. Mean diameter used was 3.02 mm, mean length 22.7 mm. Larger DCBs were used in elective cases compared with emergencies (2.94 mm vs 2.7 mm, p-value <0.05). Bail-out stenting was required in 2 cases for suboptimal results and in 1 for coronary dissection. 6 patients were re-admitted within 30-days. I had acute stent thrombosis of a non-DCB vessel due to drug non-compliance. 4 patients had no new CAD on repeat angiography. 1 was treated medically. No patient required TLR or TVR at 30-days.

Conclusion

We have demonstrated good safety and efficacy of DCBs at our centre. Our experience supports the use of DCBs in de novo coronary lesions and in large vessels although large RCTs are required to elucidate this further.