Abstracts

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WHAT ARE THE EFFECTS OF COVID-19 ON HEART FAILURE ADMISSION RATES AND MORTALITY?

1Sundas Tahir Masudi, 2Prince Josiah Joseph, 3Amna Rahman, 2Jameela Bahar, 1Abdullah Abdullah, 4Kenneth Wong. 1Dept. of Cardiology, Lancashire Cardiac Centre, Blackpool Teaching Hospitals NHS Foundation Trust, University of Liverpool, Liverpool, MSY L69 7ZX, United Kingdom; 2Dept. of Cardiology, Lancashire Cardiac Centre, Blackpool Teaching Hospitals NHS Foundation Trust, University of Liverpool, Liverpool, MSY L69 7ZX, United Kingdom; 3Dept. of Cardiology, Lancashire Cardiac Centre, Blackpool Teaching Hospitals NHS Foundation Trust, University of Liverpool, Liverpool, MSY L69 7ZX, United Kingdom; 4Dept. of Cardiology, Lancashire Cardiac Centre, Blackpool Teaching Hospitals NHS Foundation Trust, University of Liverpool, Liverpool, MSY L69 7ZX, United Kingdom

Introduction Near the beginning of the COVID-19 pandemic, a reduction in ST elevation myocardial infarction (STEMI) presentation was reported. We hypothesise that this may lead to a substantial increase in heart failure (HF) admissions and an increase in HF mortality.

Methods Consecutive admissions with HF to Blackpool Victoria hospital were categorised into three groups: pre-COVID era (defined as 01/08/2019 to 31/01/2020), first COVID wave (01/02/2020 to 31/07/2021) and the third group is second COVID wave (01/08/2021 to 31/01/2022). Inpatient mortality was the primary end point. Patients were followed up for 60 days. Secondary end point was readmissions within 60 days.

Results There were 1178 consecutive episodes of admissions with heart failure (first diagnostic position) over 18 months. 140 inpatient deaths occurred (11.8% in-hospital mortality). Three-hundred and forty one consecutive episodes of HF admissions during the 6 months of the pre-COVID era were seen. A substantial increase in number of HF presentations was observed in the first wave (422 episodes). During the second wave, this remained high compared with the pre-COVID era: 415 episodes. In the pre-COVID era, 35/341(10%) died as inpatient. During the first wave, mortality remained 10% (41/422). However, there was statistically significant increase in mortality with the second wave, 64/415 died (15%) (p=0.036 comparing pre-COVID vs second wave; p=0.013 comparing the first and second wave). In the pre-COVID era, 27% of patients were re-admitted within 60 days. By contrast 24% were admitted within 60 days during the first COVID wave and 19% during the second COVID wave (overall p=0.04). Post-hoc analysis showed there was significantly lower readmission between pre-COVID era and the 2nd wave. (p=0.015) [Table 1].

Conclusion The number of consecutive episodes of HF admissions has increased compared with the pre-COVID era. There were no changes in mortality between the pre-COVID era and the first wave however there was a statistically significant increase in mortality with the second wave.

Conflict of Interest None

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AUTOMATED DEVICE-HEART FAILURE AUDIT TOOLS IDENTIFY HIGH-RISK SUB-OPTIMALLY MANAGED HF PATIENTS

1Aman Sanghera, 2Foizia Ahmed, 3Angela Sharpe, 4Cameron Ashraf. 1Manchester Royal Infirmary, Manchester Heart Centre, Oxford Road, Manchester, G11 9OW, United Kingdom; 2Manchester Royal Infirmary; 3Medtronic Limited; 4University of Manchester

Introduction Chronic heart failure (HF) guidelines advocate that all patients with HF should undergo clinical assessment, at least 6-monthly for those who are stable, or more frequently if the clinical condition has changed. Despite this, many patients with less than optimally managed HF are not known to specialist HF services. Cardiac implantable electronic devices (CIEDs), often used in the treatment of HF can also be used to identify patients who are unstable or sub-optimally managed. The validated TriageHF algorithm in enabled CIEDs combines multi-parametric data (Table 1) to stratify patients as...
A 5-YEAR SINGLE-CENTRE EXPERIENCE OF MANAGING PATIENTS WITH CARDIORENAL SYNDROME IN THE MULTI-DISCIPLINARY CARDIARENOLOGIC CLINIC

Mithilesh Joshi, Patrick Tran, Michael Kuehl, Waqar Ayub, Rowan Hamer, Laith Khweir, Prithwish Banerjee. University Hospital Coventry and Warwickshire, Clifford Bridge Rd, Coventry, COV CV2 2DX, United Kingdom; University Hospital Coventry and Warwickshire

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Introduction Despite the recent inclusion of advanced chronic kidney disease (CKD) in modern heart failure (HF) trials such as DAPA-CKD, cardiorenal syndrome (CRS) remains an under-treated disorder with a paucity of evidence-based therapies. Cardiorenal clinics (CRC) have emerged as a collaborative initiative between cardiologists and nephrologists to provide a multi-disciplinary approach. To date, little data exist on the performance and outcomes of this clinic model. This study provides insight into how patient characteristics influence decisions on the choice of renal replacement therapy (RRT), and whether such decisions affect patient outcomes.

Methods This was a single-centre retrospective study of 151 consecutive patients who were referred to the CRC from primary and secondary care between January 2016 and March 2020. Criteria for referral were patients with an estimated glomerular filtration rate ≤30 mL/min/1.73 m² and HF, regardless of ejection fraction. CRC consisted of a consultant nephrologist and cardiologist with a specialist interest in HF. All-cause mortality and hospitalisations within 12 months from the last clinic appointment were compared between patients managed conservatively and those on RRT. Morbidity outcomes before and after RRT include changes in New York