Abstract 131 Table 1 The correlation of NYHA scale and EFI with PHQ-9 score and GAD

<table>
<thead>
<tr>
<th>NYHA SCALE</th>
<th>EFI</th>
<th>PHQ9</th>
<th>GAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>34</td>
<td>4-active</td>
<td>27</td>
</tr>
<tr>
<td>2</td>
<td>49</td>
<td>5-mild</td>
<td>33</td>
</tr>
<tr>
<td>3</td>
<td>28</td>
<td>6-</td>
<td>42</td>
</tr>
<tr>
<td>4</td>
<td>11</td>
<td>7-severe</td>
<td>12</td>
</tr>
</tbody>
</table>

Results Our data shows a higher than previously reported prevalence of depression and anxiety because of active case finding as part of their Long-term condition reviews. In our database of 122 patients, the New York Heart Association score severity correlated with the clinical frailty scale indices and the Depression (PHQ-9) and Anxiety (GAD scores).

Conclusions Patient with heart failure have a higher mental health morbidity that patients with similar electronic frailty indices without heart failure. Heart failure due to its impact on their quality-of-life multiple hospital visits and admission medication burden especially of beta blockers worsens the depression. Historical studies allude to lower rates of detection of anxiety as to some extent beta blockers may limit the physical perception of anxiety by masking physical signs of tachycardia. We advocate active case finding in patients with heart failure and depression in order to address these mental health co-morbidities with targeted psychotherapeutic treatments as these relate to higher hospital admission rates increase health care costs and poorer quality of life scores.

Conflict of Interest None

132 COULD AN INCREASED FOCUS ON HEART FAILURE MEDICATIONS POST ICD/CRT-D IMPLANT FOR PRIMARY PREVENTION OF SUDDEN CARDIAC DEATH REDUCE DEVICE THERAPY RATES?

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Intervention Implantation of an ICD or CRT-D device can provide lifesaving treatment of ventricular arrhythmias. This benefit, while enormous to any individual receiving therapy from their device, is offset by the risk of device related complications and costs to the healthcare system. The 2016 DANISH study has raised questions about the benefits provided by primary prevention ICD/CRT-D devices, particularly in the setting of non-ischaemic cardiomyopathy. We chose to investigate the frequency of successful treatment of ventricular arrhythmia in our population of patients with such devices in situ.

Methods We included all patients under the care of the cardiology team at the Royal Edward Albert Infirmary in Wigan with an ICD or CRT-D device implanted between September 2015 and January 2020. We excluded all patients with a secondary prevention indication for device implantation and patients with conditions for which specific guidelines for device implantation exist, such as hypertrophic and arrhythmogenic cardiomyopathy. We reviewed the device programming reports from the date of insertion to 1st March 2021 to record any device therapy delivered, excluding any inappropriate therapy. We collected relevant demographic and clinical data from our electronic patient record system.

Results We included 170 patients in our study. The mean time with a device in situ was 3.5 years. 165 (97.1%) of patients had echocardiographic evidence of severe left ventricular systolic dysfunction (ejection fraction ≤35%). 32 (18.8%) of patients received appropriate and successful anti-tachycardia pacing or cardioversion / defibrillation, 86 (50.6%) of patients had a diagnosis of ischaemic cardiology. 84 (49.4%) had a non-ischaemic heart failure aetiology. Of the patients that received device therapy 16 (50.0%) were diagnosed with ischaemic cardiology and 16 (50.0%) had a non-ischaemic diagnosis. When reviewing patient records 21.8% (37) had up to date documentation of heart failure medications and doses.

Conclusion Our data shows that a significant proportion of our patients are having ventricular arrhythmias successfully terminated by their ICD/CRT-D devices. This applies to patients with both ischaemic and non-ischaemic cardiomyopathy. These data support the continued implantation of ICD and CRT-D devices for primary prevention of sudden cardiac death in patients with severe left ventricular dysfunction and can help guide decision making for patients and clinicians. A key finding was the low level of documentation and discussion of heart failure medications in patients post ICD implant. The ESC guidelines are clear regarding the requirement for optimal medical therapy prior to ICD/CRT-D implant. We note the relatively high rate of ICD/CRT-D therapy in our patient population and are planning further work to investigate whether a continued focus on optimisation of medications post implant, including the addition of newer agents, may reduce rates of device therapy.

Conflict of Interest Nil

133 INVESTIGATING HOW OFTEN DAILY WEIGHTS ARE RECORDED IN ACUTE HEART FAILURE PATIENTS ON DIURETIC TREATMENT

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Introduction Acute heart failure (AHF) is a leading cause of hospital admissions and can present as new-onset or decompensated chronic heart failure. Symptoms arise from a build-up of fluid in the lungs or body causing dyspnoea and peripheral oedema, respectively. The mainstay of treatment of fluid retention is diuretics. NICE and local guidelines recommend close monitoring of weight whilst on treatment. Daily weights are an objective measure of fluid balance and guide titration of diuretic dose. We noted that within an acute unit in a busy tertiary hospital these body weight measurements were not always recorded consistently. Our aim was to investigate how
often daily weights are documented in AHF inpatients. We also wanted to explore whether prescribing daily weights is associated with higher documentation rates. Method: A retrospective analysis of 55 inpatients referred to the AHF specialist team between 1st November and 31st December 2021 was performed. Patients were required to fit stringent inclusion and exclusion criteria. For each patient, we recorded the total length of stay in days and the number of daily weights documented. As part of the secondary analysis, we hypothesised that patients with ‘daily weights’ written on the drug chart would have higher documentation rates. Therefore, we also recorded if patients had ‘daily weights’ or similar prescribed. Documentation rates were compared, between patients prescribed daily weights on the drug chart and those who were not, with an unpaired T-test. Results: There were 32 patients who met our criteria. On average, weights were recorded only 46% of admission days [Figure 1]. Prescribing ‘daily weights’ was associated with significantly higher documentation rates (83% vs 46%, p<0.05), however only 25% of patients had these prescribed [Figure 2]. Daily weights may not always be prioritised in busy departments, can be missed in handovers and when patients are moved downstream. Prescribing ‘daily weights’ acts as an automated reminder to healthcare staff to measure and monitor this parameter, with the added benefit of allowing easy comparison of diuretic dose and effect.

Conclusion This audit highlights the problem of inconsistent measurement and recording of daily weights. There is large scope for improving this and we have identified a novel method for addressing this. These findings will form the basis of our quality improvement project.

Conflict of Interest None

Abstract 134 UTILISATION OF SODIUM GLUCOSE TRANSPORT PROTEIN 2 (SGLT2) INHIBITOR IN PATIENTS WITH CARDIAC RESYNCHRONISATION THERAPY (CRT) DEVICE: A UK DISTRICT GENERAL HOSPITAL PERSPECTIVE

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Introduction SGLT2 inhibitors are proven to reduce mortality and hospitalisation in heart failure patients. Dapagliflozin is the first one to be approved in the UK in February 2021 for its use in patients with heart failure. Empagliflozin is currently being reviewed to be added on the list. In local clinical practice, we rarely see patients being prescribed this medication despite its known advantages. Method We reviewed our cohort