central death notification and publicly accessible online death notifications. Proximity from home address to the nearest PPCI centre was determined using Google Maps. Statistical analyses were performed using Stata.

**Results**

7,486 STEMI patients were identified from January 2013 – March 2018. 6,612 were included in the analysis. Minimum follow up was 3 years, median follow up was 5.5 years. 4,040 received timely PPCI, 2,162 delayed PPCI, 335 t-PA. Baseline characteristics are shown in table 1. There was no difference in survival between the timely PPCI (84.7%) and t-PA groups (84.2%) (HR 0.93, 95%CI 0.71–1.25; Log-Rank p=0.62). There was increased mortality in the delayed PPCI (80.6%) in comparison with both timely PPCI (HR 1.5, 95%CI 1.16–1.49; Log-Rank p<0.000) and t-PA groups (HR 1.23, 95%CI 0.93–1.66; Log-Rank p=0.16), figure 1, 2.

**Conclusion**

Patients who were treated with a pharmaco-invasive strategy had lower all-cause mortality on long term follow up versus those who received PPCI outside of the target treatment window. Given the high proportion of patients who received delayed PPCI (33%), consideration should be given to expanding a pharmaco-invasive approach to patients who are unlikely to receive timely PPCI.

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**Oral abstract presentations 2**

12 PREVALENCE OF TRANSTHYRETIN AMYLOID CARDIOMYOPATHY (ATTR-CM) IN UNDIFFERENTIATED HFpEF


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**Introduction**

Transthyretin amyloid cardiomyopathy (aTTR-CM) is an increasingly recognised cause of heart failure with preserved ejection fraction (HFpEF) which may be diagnosed non-invasively with SPECT/CT 99m-3,3-diphosphono-1,2-propanodicarboxylic acid (DPD) scintigraphy. The diagnosis of aTTR-CM has assumed greater relevance with the growing availability of diagnostic modalities, were not eligible for ICA or if they included patients with possible acute coronary syndrome. The four included randomised trials were Discharge, CAT-CAD, Conserve and CADMAN. Primary outcomes were the rate of PCI and CABG. Secondary safety outcomes included MACE, diagnosis of obstructive disease and bail-out ICA in those originally randomised to the CTCA group.

**Results**

Meta-analysis of the randomised trials demonstrated a significant decrease in PCI (OR 0.72 95% CI [0.62, 0.89]) and CABG rates (OR 0.6 95% CI [0.42, 0.85]) with a CTCA first approach. There was no significant difference in the rates of MACE (OR 0.83 [0.61, 1.12]) with numerically fewer events in the CTCA arm. There was no difference in obstructive coronary artery disease rates between the two arms. Rates of a subsequent ICA in the CTCA group were 8.6% (244/2819) Vs 98% (2645/2694) in the ICA group (figure 1).

**Conclusion**

This meta-analysis of 5613 patients with an indication for an ICA demonstrates a significant reduction in rates of PCI and CABG when managed with a CTCA first approach. There was no significant difference in rates of MACE between the two approaches. A CTCA first approach may represent a less invasive first-line diagnostic technique for many patients.
MORBIDLY OBESE PATIENTS WITH SYMPTOMATIC SEVERE AORTIC STENOSIS, WHAT IS THE OPTIMAL TREATMENT STRATEGY? A PROPENSITY SCORE MATCHED ANALYSIS OF TRANSCATHETER VERSUS SURGICAL AORTIC VALVE REPLACEMENT

Background The prevalence of morbid obesity (MO) is increasing worldwide and consequently increasing numbers of morbidly obese (MO) patients are undergoing transcatheter (TAVR) and surgical (SAVR) aortic valve replacement for severe aortic stenosis (AS). Currently, no head to head randomized data exists to inform the optimal treatment strategy in this cohort. We aimed to compare the periprocedural and mid-term outcomes in MO patients undergoing TAVR versus SAVR.

Methods We performed a multicentre retrospective study including consecutive MO patients (BMI ≥40kg/m², or ≥35kg/m² with obesity related co-morbidities) undergoing either TAVR (n=860) or biological SAVR (n=696) for severe AS. Eighteen centres from Europe, North and South America were included. To control for differences in baseline characteristics between groups, propensity score matching was performed resulting in 362 pairs.

Results After matching, periprocedural complications including blood transfusion (14.1% versus 48.1%, p<0.001), stage 2–3 acute kidney injury (3.9% versus 10.1%, p=0.002), hospital acquired pneumonia (1.7% versus 5.8%, p=0.005), and access site infection (1.5% versus 5.5%, p=0.013) were more common in the SAVR group, as was moderate-severe patient prosthesis mismatch (PPM) (9.9% versus 39.4%, p<0.001). TAVR patients more frequently required permanent pacemaker implantation (14.4% versus 5.6%, p<0.001) and had higher rates of moderate residual aortic regurgitation (3.3% versus 0%,