Background Guidelines advise that patients suffering ST-elevation myocardial infarction (STEMI) are revascularized as quickly as possible. If a patient is likely to receive primary percutaneous coronary intervention (PPCI) within 120 mins from diagnosis then this is the preferred treatment strategy. PPCI can only be delivered in specialist centres and timely access can be determined by geographical location. In the south-east region of Ireland, currently only in-hours PPCI care is provided in a single specialist centre. We wished to determine whether patients from the South East had different survival following STEMI than those in the rest of Ireland.

Methods All STEMI patients from January 2013 until March 2018 were identified from the Irish national acute coronary syndrome (ACS) registry. Ethical approval and a consent declaration were obtained before accessing data. STEMI patients treated in the single regional specialist centre in the south-east region were identified from an internal hospital database. Patients treated in the south-east region comprised those treated at either the single regional specialist centre and those patients treated after transfer to specialist centres outside the region. The comparator group comprised the remainder of patients with STEMI in the rest of Ireland. Survival was determined from the national death register. Proximity to nearest...
primary PCI centre was determined from Google Maps. Statistical analyses were performed using Stata.

**Results** 7,483 patients were included in the analysis – 678 in the south-east region (371 treated in the regional centre, 307 transferred outside the region), 6,805 in the rest of Ireland. Minimum follow up was 3 years, median follow up 5.5 years. Baseline characteristics are displayed in table 1. Patients in the South East had similar survival (83.6%) to those in the rest of Ireland (81.9%), Log-Rank p = 0.11; HR 0.85 (p = 0.088 95% CI 0.69–1.03) (figure 1).

**Conclusion** Patients living in the south-east region of Ireland showed similar unadjusted survival following STEMI compared to patients living in the rest of Ireland.

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**BRUGADA AND DRIVING: TIME TO RETHINK DRIVING RESTRICTION?**

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**Introduction** Brugada syndrome (BrS) is an inherited channelopathy which is usually caused by mutation in the SCN5A gene. The coved ST-segment elevation in the right precordial leads is diagnostic and can predispose to polymorphic ventricular tachycardia (VT) and sudden death (figure 1). In Ireland, BrS cases with secondary prevention implantable cardioverter defibrillators (ICDs) are unable to drive. This recommendation was based on the consensus statement of the European Heart Rhythm Association in 2009. However, increasing data suggests that educating patients to avoid heavy meals and alcohol before sleep, prompt treatment of pyrexia, and avoid certain drugs greatly reduces risk of VT. In addition, Quinidine and more recently epicardial ablation have proven effective. Furthermore, our threshold to implant a device is higher, due to a clearer definition of arrhythmogenic syncope and the reduced use of programmed electrical stimulation (PES). These developments prompted a review of current national guidelines, and our own data.

**Methods** Retrospective analysis of BrS patients who attend an adult inherited cardiac conditions clinic (Tallaght University Hospital and Mater Misericordiae University Hospital). Local records and the national device database Heart rhythm Ireland were utilised.

**Results** A total of 10 BrS patients with ICDs were identified. Mean age was 50 years, and 7 were male. One case underwent implantation for primary prevention due to high-risk features. Regarding the secondary prevention cohort; 2 had survived a cardiac arrest, 3 had syncope without documented arrhythmia, and 4 had non-sustained VT or a positive PES. A subcutaneous ICD was utilised for 2 patients. Mean follow up time since implant was 7 years and 3 months. Defibrillation therapy was required for 2 patients, each of which was appropriate and occurred during sleep. Both have been free of ventricular arrhythmias since commencement of Quinidine or having undergone an epicardial ablation.

**Conclusion** BrS secondary prevention ICDs have rarely been performed in Ireland. In terms of risk when driving, ventricular arrhythmias only occurred during sleep, a pathognomonic trigger in BrS. Given the improved understanding of BrS and the development of effective treatments, several countries have removed the indefinite driving restriction for a category one license. Our national data is consistent with this trend and can now be included in a review of Irish driving recommendations.

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**POLYMORPHIC VT FOLLOWING ANAPHYLAXIS TO COVID-19 VACCINATION**

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**Introduction** There is little known regarding the potential cardiovascular effects, of the novel SARS-CoV-2 vaccines. There is a documented association between the vaccines and myocarditis, especially in young males. To date, a sparsity of evidence exists regarding associations of arrhythmias with the SARS-CoV-2 vaccines. We present the case of a 42 year old lady, who was transferred to our hospital, following an out of hospital cardiac arrest. This was on the background of a recent discharge from her local hospital, after an anaphylactic reaction to the Pfizer/BioNTech Covid-19 vaccine. She suffered a cardiac arrest and received bystander cardiopulmonary resuscitation, with two shocks delivered by an automated defibrillator (AED) at the scene. Rhythm strips obtained from the AED, demonstrated polymorphic ventricular tachycardia. Cardiac Investigations including Echocardiography and CT Coronary Angiography were unremarkable. During her admission, she developed persistent episodes of non-sustained ventricular tachycardia, with R-on-T phenomenon. (Figure 1) She was