

patients received epicardial pacing (16 male, 9 female), with mean follow-up of 7 years. The average age for the transvenous pacing was higher at 26.3 ± 9.5 years when compared to epicardial pacing at 14.6 ± 14.5 years ($p=0.009$). Summary of demographics is shown in Table 1. Data on pacemaker type and follow up could not be retrieved for 1 patient.

The main indications for pacing were sinus node dysfunction and complete heart block. Transvenous pacing was demonstrated in LT-TCPC and AP Fontan circulation but in our cohort, there were no patients paced transvenously from the EC group (Figure 2). In patients who underwent transvenous ventricular pacing the approaches included access through baffle fenestration, baffle puncture or via persistent left sided superior vena cava.

Pacing parameters were checked at 6-weeks and 6-months post insertion (Table 2). The right atrial pacing threshold at 6-weeks was higher in the transvenous group ($p=0.032$) with no other significant differences between epicardial and transvenous pacing parameters ($p>0.05$). Frequency of box changes was similar across groups ($p=0.221$).

There were no acute or chronic complications such as pneumothoraces, lead displacements, or haematomas in any transvenous case.

Conclusion This study has shown that a transvenous pacing approach appears to be feasible and safe in AP and LT Fontan circulations, with similar pacing parameters at 6 week and 6 month follow up to those paced epicardially.

Conflict of Interest None

14 EXPERIENCES IN ESTABLISHING A SPECIALTY DOCTOR-LED AORTIC VALVE SURVEILLANCE SERVICE FOR AORTIC STENOSIS

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Introduction Covid-19 had a major impact on the landscape of UK healthcare, to the detriment of already strained services. Unacceptable delays in care and loss to follow-up became a real risk for patients with chronic conditions like aortic stenosis (AS).

AS is a progressive disease with proven mortality risk once it becomes severe. Following two serious adverse incidents in Northern Ireland (NI) relating to the death of such patients, we set out to establish a dedicated aortic valve surveillance (AVS) service.

Methods We designed, developed and delivered a centralised service for AS patients in the Southern Health and Social Care Trust. It is led by specialty doctors with governance from consultant Cardiologists.

We wrote a business plan, identified funding streams and recruited appropriately experienced staff. In conjunction with key stakeholders we devised a standard operating procedure (SOP) to guide the patient's journey from referral to exit. This clearly defines surveillance intervals and expected management depending on severity, and was written with reference to contemporaneous European Society of Cardiology guidelines.

To capture patients, our sonographers were trained to include recommendation for AVS referral in their TTE reports if a scan shows AS. We also created a referral proforma outlining inclusion/exclusion criteria. All referrals are medically

triaged at the point of access, and each patient assigned a named consultant to whom they can be exited for heart team (HTM) workup once intervention triggers are met.

We collaborated with cardiac investigations to create managed Echocardiogram lists and secured two clinics per week to review those with moderate AS or higher. All of this activity is tracked through the creation of a live, searchable database.

We designed templates for triage outcomes, clinic reviews and results letters to ensure uniformity of documentation and aid replicability.

Results We currently have 1400 patients enrolled in our service, all receiving ESC guideline-directed care. We have demonstrated initial safety success with earlier access to HTM discussions for those meeting intervention criteria. More patients are getting their imaging surveillance on time through the use of managed lists. We are formally auditing the service against set standards and anticipate that adherence will be greater than 90%.

Conclusions Our comprehensive, streamlined service is the first of its kind in NI and provides protocolised care for AS patients within the Southern Trust. Our tracking system minimises risk of attrition to follow-up.

By centralising AS care, we have reduced duplication of appointments and investigations. Triage referrals prior to inclusion limits inappropriate surveillance of patients unsuitable for intervention. This all results in more efficient and equitable use of finite resources.

Finally, we are proudly championing specialty doctors in cardiology by placing them at the forefront of our work.

Conflict of Interest None

15 FINDINGS IN ACUTE CORONARY ANGIOGRAPHY IN INDIVIDUALS WITH HYPERTROPHIC CARDIOMYOPATHY

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Background Hypertrophic Cardiomyopathy (HCM) is a common inherited cardiac condition, affecting 1 in 500 people. HCM can present clinically with features mimicking acute coronary syndrome, such as chest pain, electrocardiogram (ECG) changes and cardiac biomarker elevation. Because of the overlap in symptoms and signs between HCM and coronary artery disease (CAD), patients with HCM with normal coronary arteries may undergo unnecessary invasive coronary angiography; in two registry settings HCM accounted for approximately 5% of patients with normal coronaries undergoing primary percutaneous coronary intervention (PPCI) activation. Whilst the results of elective coronary angiography in individuals with HCM have been described, surprisingly little is known about the angiographic findings in patients with HCM undergoing urgent or accelerated angiography for assessment of suspected acute coronary syndrome.

Purpose In a cohort of HCM patients, we assessed the prevalence of non-obstructive coronary arteries (NOCA) at inpatient coronary angiography, the numbers undergoing repeat angiography acutely and the prevalence of NOCA in the acute setting during their index presentation.

Methods Retrospective cohort analysis of patients identified from a prospective HCM Registry at a large tertiary centre in