the United Kingdom, in whom coronary angiography was performed for assessment of suspected acute coronary syndrome, including ST-Elevation Myocardial Infarction.

Results 123 out of 698 HCM patients enrolled in the registry who had undergone coronary angiography were identified (mean age 61 years, male 83 patients, 68%) (Table 1). 111 (90.2%) patients underwent one coronary angiogram and 12 (9.8%) patients had more than one procedure. There were 140 coronary angiograms in total (Figure 1). Inpatient and outpatient angiography was performed in 44 (36%) and 79 (64%) patients respectively. NOCA were identified in 83% of urgent inpatient angiograms, 78% of emergency angiograms and 78% of elective angiograms. 29 patients admitted acutely with chest pain had NOCA and of these, 21 patients did not have a pre-existing diagnosis of HCM. For the 21 undiagnosed patients, the median time from angiography to confirmed HCM diagnosis was 9 (Inter Quartile Range, IQR 0-59) months.

Conclusions The prevalence of NOCA in patients undergoing acute coronary angiography in HCM is far higher than reported for all-comers in large disease registries, confirming that the overlap between HCM and ACS causes diagnostic difficulty. The inpatient finding of NOCA was common in undiagnosed HCM patients and followed by a significant delay in the diagnosis. HCM should be considered in patients with NOCA and fixed ECG changes. These findings argue for strategies to reduce the number of invasive angiograms undertaken and to minimise the diagnostic delay in patients presenting with suggestive features.

Conflict of Interest none

16 SCREENING FOR AND MONITORING FONTAN-ASSOCIATED LIVER DISEASE IN A TERTIARY CENTRE

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Introduction Fontan-associated Liver Disease (FALD) is a common extracardiac complication of the Fontan circulation which
carries substantial morbidity and mortality. Effective screening for FALD and monitoring of established FALD is paramount in order to prevent complications and inform management on future treatment including transplantation.

**Purpose**

This project was a re-audit of the adherence to guidelines on screening and monitoring of FALD in a tertiary adult congenital heart disease referral centre. We have previously published the results of the first audit cycle, which found suboptimal adherence and introduced change in the form of departmental education and promotion of a Fontan blood test bundle. We re-audited our practice to assess our practice following the change introduced.

**Methods**

1. A total of 256 Fontan patients reviewed at our centre between 1977 and 2020 were identified from the congenital cardiac surgical database, and 81 patients were included in the first audit cycle.
2. Data for this re-audit was collected by review of electronic records for all the included patients in the 1st cycle of the audit, between 31st January 2020 and 1st April 2022.
3. The following patients were excluded from the 2nd audit cycle: Patients followed up outside our Trust, and patients

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**Abstract 16 Table 1**

<table>
<thead>
<tr>
<th>Fontan blood tests:</th>
<th>Fontan imaging:</th>
</tr>
</thead>
<tbody>
<tr>
<td>full blood count</td>
<td>Abdominal ultrasound (+/- elastography)</td>
</tr>
<tr>
<td>urea and electrolytes</td>
<td>CT liver</td>
</tr>
<tr>
<td>liver function tests</td>
<td>MRI liver (+/- MRI elastography)</td>
</tr>
<tr>
<td>alpha-fetoprotein</td>
<td>international normalized ratio (INR)</td>
</tr>
</tbody>
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**Abstract 16 Figure 1** Results of screening for Fontan-associated liver disease

**Abstract 16 Figure 2** Results of monitoring known Fontan-associated liver disease

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who died. The final study population for the second audit cycle included 65 patients.

Results Of the 65 patients (37 male, median age 26 [19-43] years), the median age of Fontan completion was 5 (0-25) years. The median follow-up period since Fontan completion was 20 (8-39) years. 49% (32/65) cases had abnormal findings on imaging (ultrasound/CT/MRI) suggestive of FALD and constituted the monitoring group with known FALD. The rest 33 patients were screened for possible FALD (screening group).

With regards to screening for FALD, the guidelines recommended history taking and physical examination once a year, with blood tests and imaging (listed in table 1) once every 3 years. History taking and physical examination were documented in 94% of patients. 91% had blood tests, while imaging was performed in 100% of cases in the last 3 years.

Regarding monitoring of previously diagnosed FALD, the guidelines recommended history taking, examination, blood tests and imaging, and hepatology review every 6 months. At 6 months, history and physical examination were documented in 75% and 77% of patients respectively. 75% had blood tests taken, and imaging was performed in 66% of cases. It is worth noting that our departmental policy is to perform these once a year, by which time most patients had history, examination, blood tests and imaging performed (94%, 97%, 91% and 91% respectively). Hepatology referral was made in 56% of these cases and the majority were discharged back to our team. However, most patients with established cirrhosis and portal hypertension remained under Hepatology.

In comparison with the low adherence to guidelines during the first audit cycle, both in the screening group (66% for examination at 1 year, 52% for Fontan blood tests and 68% for imaging at 3 years), and the monitoring group (68% for examination, only 35% for Fontan blood tests and 51% for imaging at 1 year), and allowing for the changes made to the selection criteria of the audited patient group, this represents significant improvement to our practice.

Conclusions Overall, FALD screening was performed well according to international guidance. Monitoring of known FALD was frequently underperformed at 6 months, however the majority of our patients had appropriate monitoring within one year. These findings represent improvement compared to previous practice. Our patients may benefit further from advocating the use of MELD-XI score and exploring a joint cardiac hepatology Fontan clinic.

Conflict of Interest nil

Introduction Patients with a Fontan palliation are at risk of thrombosis, that can be associated with major morbidity and mortality. Studies comparing thromboprophylactic strategies in these patients tend to be retrospective with small numbers of patients. Furthermore, this is a heterogenous population leading to further difficulties when trying to apply published literature to real-world patients. Most studies have investigated aspirin and warfarin, and there is sparse data on the role of Direct Oral Anti Coagulants (DOACs) in this population. As a result, there is no consensus on the optimal thromboprophylaxis or anticoagulant in these patients. We set out to establish current UK practice in Adult Congenital Heart Disease units.

Methods An electronic survey was sent to ACHD consultants working in the NHS. This incorporated some basic demographic data and several clinical scenarios based on antithrombotic strategies of an 18-year-old patient with an Extra