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

5. The data were analysed to determine whether the screening and monitoring recommendations from current guidance were performed.

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

Abstract 17 Figure 1 Level of comfort using DOACs in adults with a Fontan palliation

■ A) Very, I often use them first line
■ B) Somewhat, but still usually pick alternative
■ C) Not entirely, but will use in select cases

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Cardiac (EC) Fontan palliation. Users were given a pre-specified checklist of options including ‘aspirin’, ‘DOAC’ or ‘warfarin’ with the option to create an alternative free text answer. Data was analysed using simple descriptive statistics.

**Results** There were 32 respondents, 28 of these were from level 1 centres, 3 from level 2 centres and 1 from a level 3 centre. 97% were consultants. There were varying levels of comfort with regard to DOACs in this population (see Figure 1). All respondents would use a DOAC, 35% being very comfortable with their use, 42% being somewhat comfortable but would still usually pick an alternative, and 23% would only use a DOAC in selected cases. The primary reasons for not using DOACs in these patients (see Table 1) included lack of evidence (58%), concerns regarding thrombotic risk (39%) and concerns regarding bleeding risk (26%).

In the primary scenario involving an 18-year-old with an EC Fontan and an reassuring echo with no history of thrombosis, arrhythmia, or bleeding (see Figure 2), most respondents would anticoagulate with either a DOAC (32%) or warfarin (29%); just under a quarter (23%) would use aspirin and 16% of respondents answered with some ambiguity or selected ‘other’ with free text options such as ‘dual anti-platelet therapy’ and ‘no medication’. In an 18-year-old with an EC Fontan and a history of atrial arrhythmia, 100% of respondents would anticoagulate with just over half (53%) opting for warfarin. A history of intra-cardiac clot increased the selection of warfarin to 75%. DOACs were more likely to be considered first-line in patients with a severe needle phobia (72%) and an INR that was difficult to control (78%).

**Conclusion** There is a great deal of variation both within and between centres across the UK. This is likely to persist until there are larger, prospective, randomised controlled trials.

**Conflict of Interest** Nil