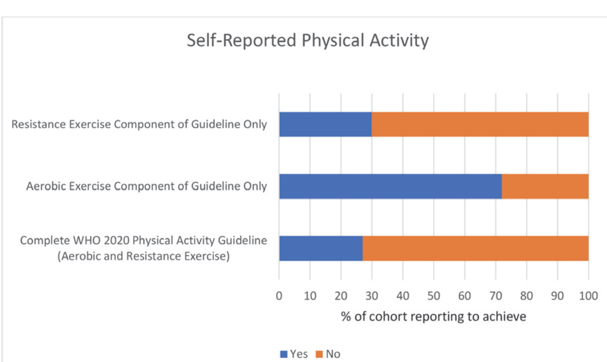
lower among the CRY Clinic patient cohort (33% vs. 27%). Additionally, reported resistance exercise levels was lower (30%) than aerobic exercise (72%). This is despite resistance exercise being additionally beneficial for many cardiac conditions. During the period of data collection, access to gyms and group exercise was limited due to pandemic government restrictions that likely effected resistance exercise more than aerobic exercise. In fact, a significant increase in recreational walking during covid restrictions was previously reported. Exercise is often discussed during medical consultation but rarely prescribed. In our cohort only 0.5% of patients received an Ex Rx. The reported barriers to Ex Rx are lack of time, perceived lack of patient engagement, complex co-morbidities and clinician education. Attempts were made in the form of education and resource provision to clinicians to challenge perceived barriers. Ex Rx are important in the CRY Clinic not only for the known benefits of PA but as inappropriate exercise can be harmful for some cardiac conditions. The Ex Rx enabled the benefit of PA to be gained by the safe promotion of appropriate exercise to such patients (figure 2). The introduction of this PA assessment and Ex Rx was a successful call to action to incorporate exercise as medicine to the CRY Clinic. 'Walking is a (wo)mans best medicine' (Hippocrates 460BC).

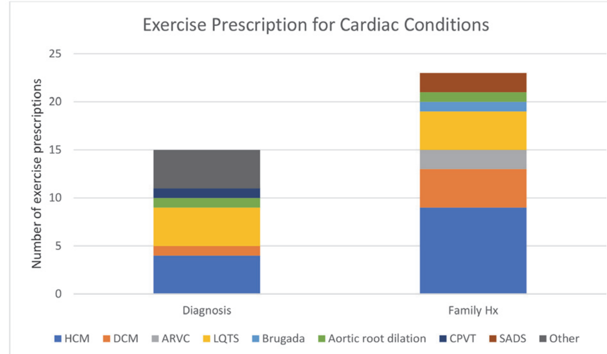
Abstract 49 Table 2 'How do I estimate exercise intensity?' patient guide as part of the exercise prescription template and patient information leaflet

Intensity	RPE	(Rating of perceived exertion)	% of HR max**	Talk test	
	0	Resting			
	1				
	2	Very light			No noticeable change in breathing or sweating
Low	3	Somewhat light	<55%	Can talk and sing	
	4	Light			
Moderate	5	Somewhat moderate	55–74%	Can talk, can't sing	Increased breathing and sweating
	6	Moderate			
	7	Somewhat hard			Feeling 'out of breath' and increased sweating
High	8	Very hard	75–90%	Can't talk or sing	
	9	Extremely hard			
	10	Maximal exertion			

**%HR max will not be an accurate measure of exercise intensity if your heart rate is effected by certain medications or conditions



Abstract 49 Figure 1 Levels of self reported physical activity based on the NAPQ-short questionnaire and WHO 2020 physical activity guidelines



Abstract 49 Figure 2 Variety of patients with a diagnosis of a cardiac condition or a family history of a cardiac condition receiving an exercise prescription. HCM; hypertrophic cardiomyopathy, DCM; dilated cardiomyopathy, ARVC; arrhythmogenic right ventricular cardiomyopathy, LQTS; long QT syndrome, Brugada; brugada Syndrome, CPVT; catecholaminergic polymorphic ventricular tachycardia, SADS; sudden adult death syndrome, Other; Friedreich's ataxia, ischemic heart disease, supraventricular tachycardia)

50 DRUG-ELUTING BALLOONS AND DRUG-ELUTING STENTS IN THE TREATMENT OF SMALL CORONARY ARTERIES: A SYSTEMATIC REVIEW AND META-ANALYSIS OF LONG-TERM CLINICAL OUTCOMES

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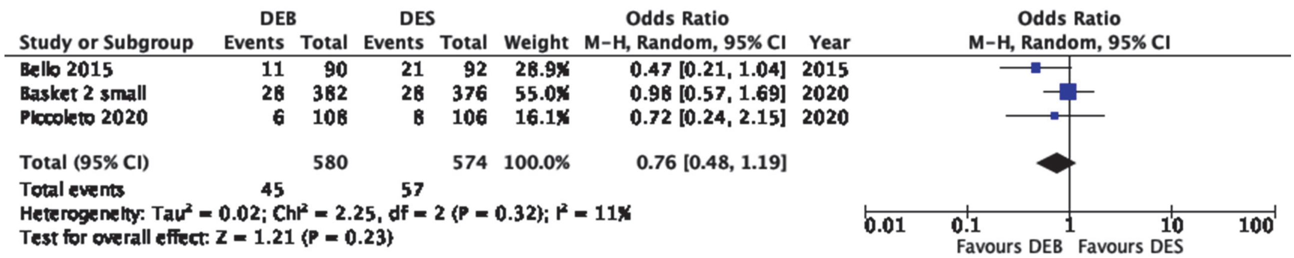
Introduction Coronary artery disease is a leading cause of mortality and morbidity worldwide. For those undergoing PCI, there are 20–30% with disease of small coronary arteries. It is often diffuse and multi-vessel and confers higher rates of major adverse cardiac events (MACE) and target lesion failure (TLF) after coronary intervention (2, 3). Best practice guidelines on the management of these small vessel interventions remain limited. Drug-eluting balloons are a novel therapy which have shown promise in treating in-stent restenosis (ISR). However, their use in small coronary arteries compared to drug-eluting stents remains unclear. This systematic review and meta-analysis of randomised controlled trials compare long-term outcomes (>1 year) of drug-eluting balloons (DEB) Vs. Drug-eluting stents (DES) in the treatment of small coronary artery disease (<3mm).

Methods A systematic review was completed within PRISMA guidelines in August 2021. The primary outcome was non-inferiority of DEB Vs. DES in major adverse cardiac events (MACE) amongst RCTs. Secondary outcomes include all-cause mortality, MI, vessel thrombosis, major bleeding, and target vessel revascularisation at one, two, and three years. Two

independent reviewers extracted data. All outcomes used the Mantel-Haenszel and Random effect model. Odds ratios (OR) were presented with a 95% confidence interval (CI).

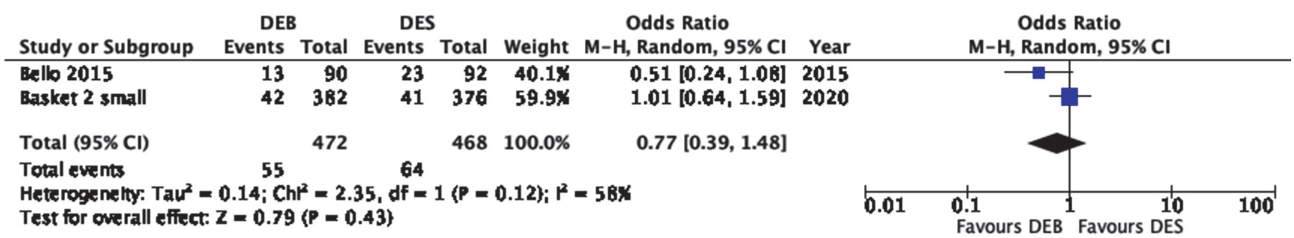
Results Results are illustrated in figure 1 to figure 11. Of 4661 articles, four RCTs were included (1414 patients). DEB demonstrated reduced rates of non-fatal MI at one year, OR 0.44, (95% CI 0.2, 0.94) (figure 5), and Basket-2 small reported a significant reduction in two-year bleeding rates OR 0.3, (95% CI 0.1, 0.91) (figure 9). DEBs were non-inferior to DES for all other outcomes.

MACE
1 Year



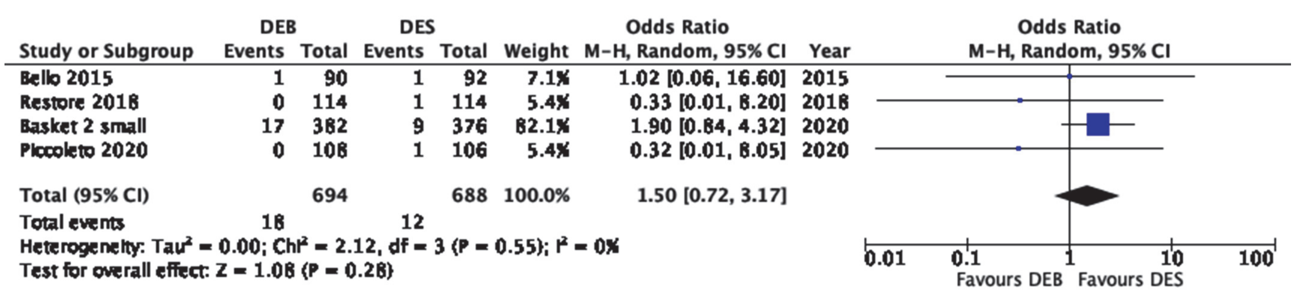
Abstract 50 Figure 1 Results

2 Year



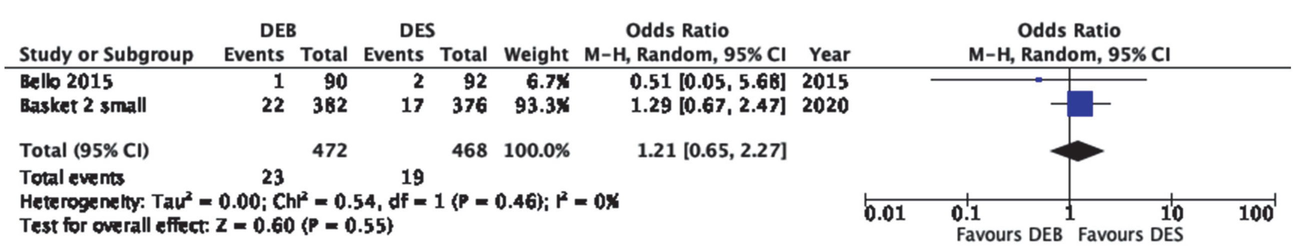
Abstract 50 Figure 2

1 year



Abstract 50 Figure 3 All-cause mortality

2 years

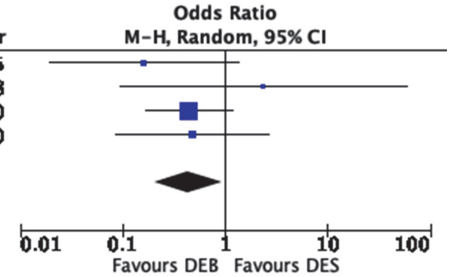


Abstract 50 Figure 4

MI
1 year

Study or Subgroup	DEB Events	DEB Total	DES Events	DES Total	Weight	Odds Ratio M-H, Random, 95% CI	Year
Bello 2015	1	90	6	92	12.9%	0.16 [0.02, 1.37]	2015
Restore 2018	1	146	0	114	5.7%	2.36 [0.10, 58.50]	2018
Basket 2 small	6	382	13	376	61.5%	0.45 [0.17, 1.18]	2020
Piccoleto 2020	2	108	4	106	19.9%	0.48 [0.09, 2.68]	2020
Total (95% CI)		726		688	100.0%	0.44 [0.20, 0.94]	
Total events	10		23				

Heterogeneity: Tau² = 0.00; Chi² = 1.92, df = 3 (P = 0.59); I² = 0%
Test for overall effect: Z = 2.12 (P = 0.03)

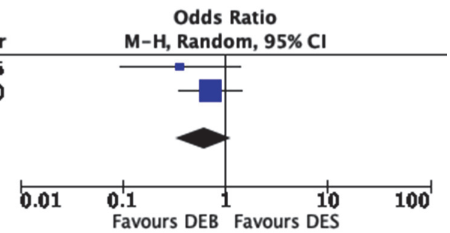


Abstract 50 Figure 5

2 years

Study or Subgroup	DEB Events	DEB Total	DES Events	DES Total	Weight	Odds Ratio M-H, Random, 95% CI	Year
Bello 2015	3	90	8	92	21.2%	0.36 [0.09, 1.41]	2015
Basket 2 small	14	382	19	376	78.8%	0.71 [0.35, 1.45]	2020
Total (95% CI)		472		468	100.0%	0.62 [0.33, 1.16]	
Total events	17		27				

Heterogeneity: Tau² = 0.00; Chi² = 0.76, df = 1 (P = 0.38); I² = 0%
Test for overall effect: Z = 1.50 (P = 0.13)

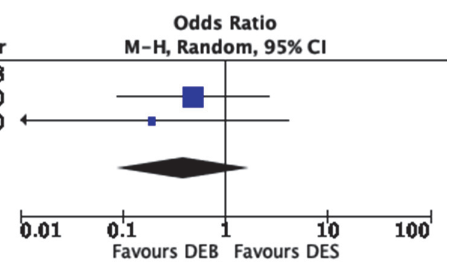


Abstract 50 Figure 6

Vessel Thrombosis
1 year

Study or Subgroup	DEB Events	DEB Total	DES Events	DES Total	Weight	Odds Ratio M-H, Random, 95% CI	Year
Restore 2018	0	146	0	114		Not estimable	2018
Basket 2 small	2	382	4	376	76.2%	0.49 [0.09, 2.69]	2020
Piccoleto 2020	0	108	2	106	23.8%	0.19 [0.01, 4.06]	2020
Total (95% CI)		636		596	100.0%	0.39 [0.09, 1.73]	
Total events	2		6				

Heterogeneity: Tau² = 0.00; Chi² = 0.28, df = 1 (P = 0.60); I² = 0%
Test for overall effect: Z = 1.23 (P = 0.22)

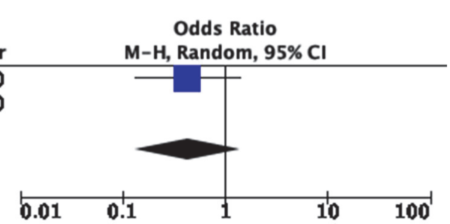


Abstract 50 Figure 7

Major bleeding
1 year

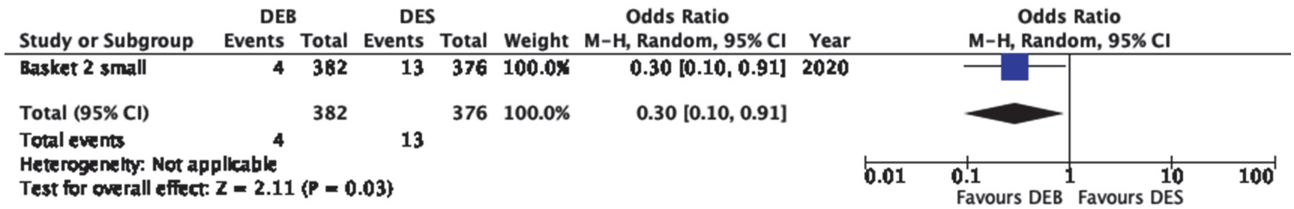
Study or Subgroup	DEB Events	DEB Total	DES Events	DES Total	Weight	Odds Ratio M-H, Random, 95% CI	Year
Basket 2 small	4	382	9	376	100.0%	0.43 [0.13, 1.41]	2020
Piccoleto 2020	0	108	0	106		Not estimable	2020
Total (95% CI)		490		482	100.0%	0.43 [0.13, 1.41]	
Total events	4		9				

Heterogeneity: Not applicable
Test for overall effect: Z = 1.39 (P = 0.17)



Abstract 50 Figure 8

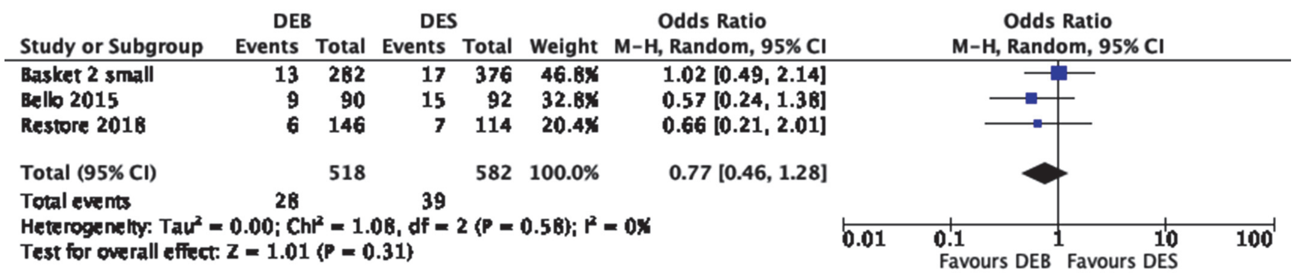
2 year



Abstract 50 Figure 9

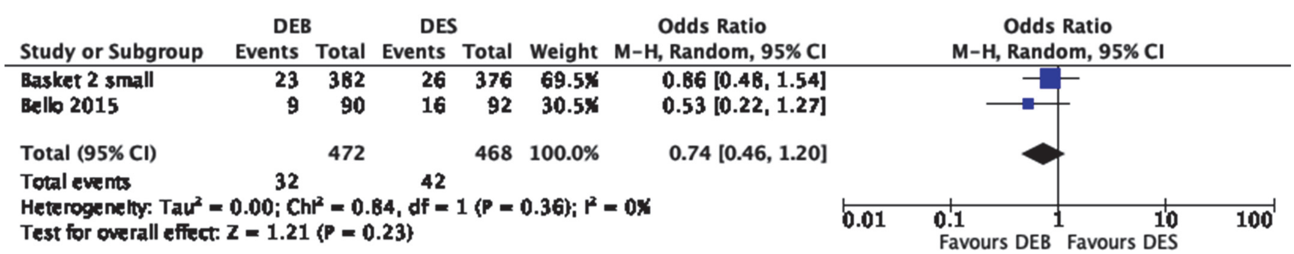
Target vessel revascularisation

1 year



Abstract 50 Figure 10

2 year



Abstract 50 Figure 11

Conclusion Long-duration follow-up of DEB and DES use in small coronary arteries demonstrates DEB to be non-inferior to DES in all outcomes across all years of follow-up. There was a significant reduction in rates of non-fatal MI at one year in the DEB arm and a reduction in major bleeding episodes at two years in the Basket Small 2 trial. These data highlight the potential utility and long-term safety of novel DEBs in small coronary artery disease revascularisation.

51 SPONTANEOUS CORONARY ARTERY DISSECTION; A SINGLE IRISH CENTER EXPERIENCE

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10.1136/heartjnl-2022-ICS.51

Introduction Spontaneous coronary artery dissection (SCAD) is a rare and under-diagnosed cause of acute coronary syndrome (ACS), representing 2–4% of cases. There are no randomised control trials on the subject, therefore management is based on observational studies, case reports and extrapolation of advice from established ACS guidelines.

Methods A search of the McKesson cardiology software identified 13 patients with a SCAD diagnosis on angiogram reports from September 2015 to February 2022. The diagnosis was made on visual inspection of the images by the operator at the time of angiogram (figure 1). Patient data was collected from both electronic records and patient charts. Microsoft Excel was used to generate descriptive statistics of the data.

Results Patient characteristics are demonstrated in table 1. The majority of patients were male (61.5%), 92.3% had a family history of ACS and 61.5% had a current or past smoking history. Laboratory values, culprit vessel and management are shown in table 2. The left anterior descending artery was most commonly affected. There was no incidence of multi-vessel SCAD. All patients were treated with aspirin and 92.3% had dual anti-platelet therapy (DAPT), which included one patient also taking an anticoagulant. Ticagrelor was used twice