with the hazard of mortality (HR 2.23; 95% CI 1.97 – 2.52). There was a progressive increase in mortality across the strata of hs-cTnI concentration (figure 1). Furthermore the log (10) hs-cTnI concentration was an independent predictor of the hazard of one year mortality (HR 1.77; 95% CI 1.64 – 1.91). The discriminative ability of hs-cTnI for one year mortality was good with an AUC of 0.75 (95%CI 0.73 – 0.76). Further, the log(10) hs-cTnI concentration was independently associated with mortality across all three locations and most strongly in the OPD cohort (IPD HR 1.49; 95% CI 1.33 – 1.67, OPD HR 2.44; 95% CI 1.95 – 3.04, ED HR 1.99; 95% CI 1.76 – 2.25).

Conclusion In a large, unselected hospital population of both in- and out-patients, 18,282 (91.4%) of whom there was no clinical indication for testing, hs-cTnI concentration was independently associated with one year mortality. These data suggest that hs-cTnI may have a role as a biomarker of future risk.

Conflict of Interest Beckman Coulter paid for all of the assays used in our studies but had no other role in the studies

185 FEMALE SPEAKER REPRESENTATION AT NATIONAL CARDIOLOGY CONFERENCES

[1]Rebecca Dobson, [1]Clare Appleby, [2]Rachel H Pathimagaraj. *[1]Liverpool Heart & Chest Hospital, Liverpool, UK; [2]University of Manchester*

10.1136/heartjnl-2021-BCS.182

Introduction Women are under-represented in cardiology in the UK (28% of cardiology trainees and 13% of cardiology consultants are female despite women accounting for >50% of medical students). Lack of female role models is one of the commonly cited reasons for the lack of women within the field. Fair representation of female speakers at national cardiology conferences is therefore important to increase the visibility of women within cardiology. We assessed the extent of female representation at UK national cardiology conferences over the last 4 years.

Methods We requested the past programmes for annual conferences from 8 national cardiology societies in the UK. The programmes were reviewed and for each chair, panellist, operator and speaker, a binary definition of gender was assigned (female or male). In cases where gender was unclear from the name, the General Medical Council (GMC) register was referred to. For those not on the GMC register, we searched for the individual online. In any remaining cases of ambiguity, we selected the gender most commonly associated with that name. Speakers presenting abstracts were excluded.

Results Programmes were obtained from 7 societies (British Cardiovascular Society (BCS), British Cardiovascular Intervention Society (BCIS), British Heart Rhythm Society (BHRS), British and Irish Hypertension Society (BIHS), British Society of Cardiovascular Magnetic Resonance (BSCMR), British Society of Echocardiography (BSE), and British Society for Heart Failure (BSH). A total of 25 annual conferences were analysed. There were a total of 3959 slots; 982 of these were female (25%). Of the 951 chair slots, 224 (24%) were female. There were 3007 speaker/panellist slots, of which 760 (25%) were female. See table 1 below for details.

Conclusion There is significant variation in the proportion of female speakers between societies (11-45%). Specialties with the lowest numbers of female consultants had the lowest female representation, however BCS which represents all subspecialties also had poor female speaker representation. No clear improvement in female numbers occurred from 2017-2020. As part of a drive to facilitate gender equality within cardiology, conference committees need to ensure that speaker panels are gender balanced to enhance visibility of women within the specialty.

Conflict of Interest None

Abstract 185 Table 1

Society Total speakers (% female) Year	BCIS	BCS	BHRS	BIHS	BSCMR	BSE	BSH
2020	169 (15%)	No conference	340 (28%)	15 (33%)	No data	98 (41%)	65 (45%)
2019	193 (17%)	367 (23%)	325 (31%)	57 (25%)	30 (30%)	92 (40%)	61 (29%)
2018	200 (14%)	245 (22%)	385 (23%)	65 (15%)	No data	90 (22%)	64 (34%)
2017	128 (13%)	372 (19%)	336 (32%)	73 (26%)	35 (11%)	93 (38%)	61 (21%)

186 EFFECTS OF AN ESTABLISHED DRUG ON SMAD SIGNALLING PATHWAY IN THE RAT MODEL OF MONOCROTALINE PULMONARY HYPERTENSION

[1]Khaled Habas, [2]Özlem Eklioğlu, [1]Talat Nasim. *[1]University of Bradford, Bradford, UK; [2]Anadolu University Faculty of Pharmacy Department of Pharmaceutical Toxicology Eskisehir/Turkey*

10.1136/heartjnl-2021-BCS.183

Introduction Pulmonary arterial hypertension (PAH) is a complex multifactorial disease with both genetic and environmental dynamics contributing to disease progression that characterized by unbalanced proliferation and apoptosis of pulmonary arterial smooth muscle cells (PASMCs) (Nasim et al., 2012). Mutations in the bone morphogenetic protein receptor type II (BMPRII) gene have been associated with development of familial pulmonary artery hypertension (PAH). The function of SMAD signal transduction during the pulmonary vasculature and the role BMPRII mutations in the development of PAH are not fully understood. However, drug or toxin-induced PAH has been characterized by raised pulmonary arterial resistance leading to right heart failure. Aim and

Methods in this study, the monocrotaline (MCT) model of PAH was used to examine alterations in SMADs (SMAD3 and SMAD1/5) signal transduction pathways in vivo. The SMAD signalling pathways were investigated in lungs harvested from rats treated with a single 50-mg/kg of MCT and an established drug at concentrations of 0.5 and 1 mg/Kg. The level of phosphorylation of SMAD3 and SMAD1/5 were detected by Western blot and the expression BMPR2, Id1, Pai1 transcripts was measured using quantitative real time PCR (qPCR).

Results MCT-treated rats decreased the level of SMAD 3 phosphorylation, which was restored following the treatment with the established drug. The drug also modulated the expression of SMAD target genes.

Heart: first published as 10.1136/heartjnl-2021-BCS.183 on 4 June 2021. Downloaded from http://heart.bmj.com/ on December 15, 2022 by guest. Protected by copyright.

Conclusion Our study suggests that loss of SMAD3 could possibly present a key event in the pathophysiology in PAH and restoring this pathway may provide therapeutic intervention.
Conflict of Interest The authors declare that there is no conflict of interest

187 GETTING IT RIGHT FIRST TIME: CT CORONARY ANGIOGRAPHY FIRST IN GP PATIENTS REFERRED TO RACPC – IS IT FEASIBLE?

John Graby, David Murphy, Rhys Metters, Katy Porter, Kady Parke, Eleanor Boden, Mzimkhulu Khumalo, Samantha Jones, Dawn Ellis, Rob Lowe, Jonathan Rodrigues. *Royal United Hospitals Bath NHS Foundation Trust, Bath, UK*

10.1136/heartjnl-2021-BCS.184

Introduction The Rapid Access Chest Pain Clinic (RACPC) targets rapid investigation, symptom relief and improved outcomes for patients with potential coronary artery disease (CAD). NICE recommends CT coronary angiography (CTCA) first line for all new onset chest pain patients without known CAD, unless pain is non-anginal with a normal ECG.

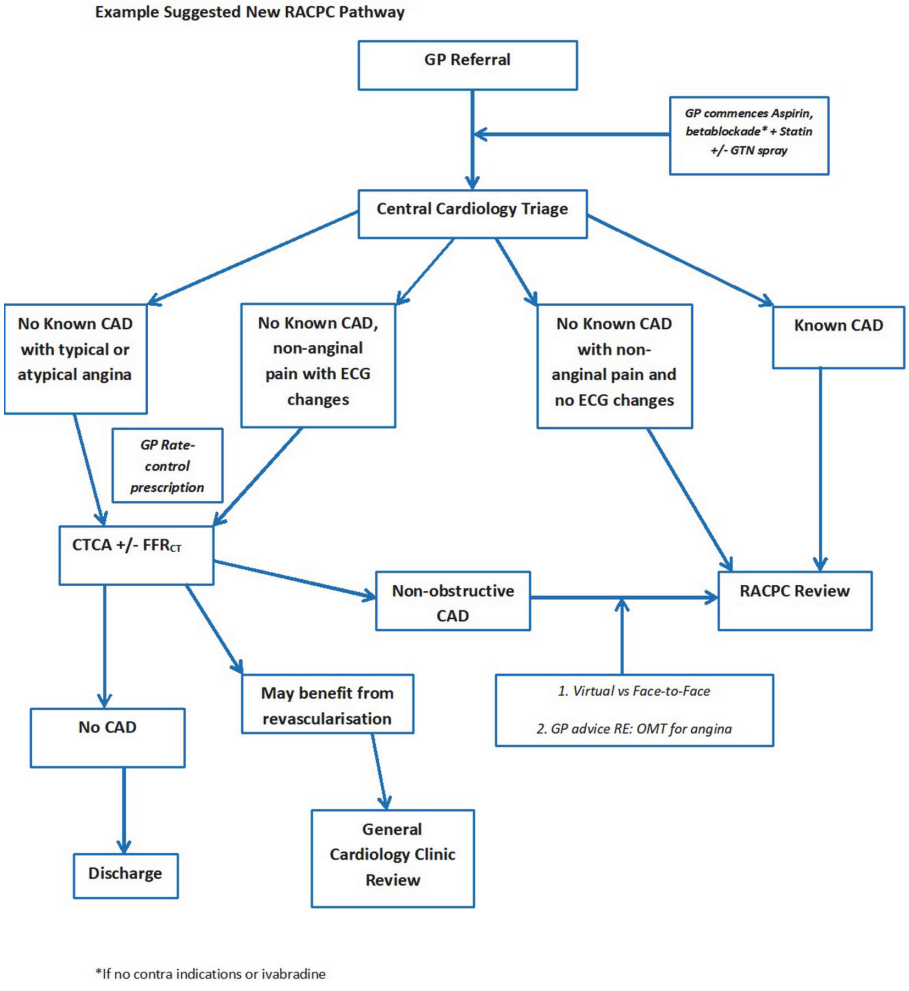
Getting It Right First Time reviews variations in service delivery to improve care, outcomes and efficiency. The RACPC pathway may be compared with 2 week wait cancer services, where investigation follows GP assessment prior to considering secondary care review.

In an era of assessing existing pathways to improve the patient journey, treatment and efficiency, this study aimed to test the hypothesis that an upfront CTCA strategy is feasible and safe for GP referrals to RACPC.

Methods A single-centre retrospective review of consecutive RACPC GP referrals September-October 2019, excluding known CAD or unavailable notes. An upfront CTCA following 'referral based triage' strategy (figure 1) was compared to existing face-to-face review and decision making. An analysis of referral content was made to facilitate safe central triage and cross-referenced with RACPC review and management. Time to diagnosis and hospital encounters were compared.

Results 107/172 patients met review criteria: median age 60 (IQR 22); 52 (49%) male. GP Referral vs RACPC: Table 1 compares GP referral and RACPC findings. Of referrals without CAD history, no prior CAD was identified at RACPC review. All murmurs at referral were confirmed at RACPC. 17 (16%) patients had murmurs newly identified at RACPC though none had ≥moderate disease.

Actual management vs hypothetical pathway: 74 CTCAs were requested via RACPC vs 61 via a hypothetical pathway, the difference relating to requests outside of NICE guidance. This would extrapolate to a reduction of 78 CTCAs annually. Upfront CTCA cuts the time from referral to RACPC (median



Abstract 187 Figure 1

Heart: first published as 10.1136/heartjnl-2021-BCS.183 on 4 June 2021. Downloaded from http://heart.bmj.com/ on December 15, 2022 by guest. Protected by copyright.