the clinic. Patients felt happier that they were given time to discuss their eye conditions and have access to support. Other staff working within the Eye clinic also felt that they further understood sight loss after receiving visual awareness training. This training was also delivered to other professionals, including occupational therapists, within the hospital who have been better equipped to assist their visual impaired patients.

Conclusions The numbers of patients living with sight loss is gradually increasing the demand on ophthalmic services. Ophthalmic services continue to have the second highest number of outpatient attendances of any speciality, placing enormous pressure on ophthalmic staff to diagnose and treat patients. Having an integrated ECLO at the West Suffolk hospital has proved invaluable. The ECLO service is a good example of how integrated secondary care and social care improve patient outcomes. Evidence has shown that the service is well used and the ECLO service is a vital part of any Eye clinic.

20 REGISTRY REPORT OF THE PREVALENCE OF ECG ABNORMALITIES AND THEIR RELATION TO PATIENT CHARACTERISTICS IN AN ASYMPTOMATIC POPULATION

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Background Cardiovascular disease is the leading cause of morbidity and mortality in developed countries. Many patients do not experience symptoms before a first major cardiovascular event. Resting electrocardiogram (ECG) may help identify asymptomatic individuals with a high risk of cardiovascular disease. We sought to determine the prevalence of ECG abnormalities in an apparently symptom-free adult population within a prospective registry.

Methods The registry consisted of 4739 consecutive apparently healthy individuals (age 62.8 ± 6.2 (SD) years; 54% female), referred by their General Practitioners between 2009 and 2013. Patient demographics, and clinical data were obtained, alongside blood tests and a resting ECG.

Results ECG abnormalities were present in 1509 (31.8%) subjects and were commoner with increasing age ($F=0.161$, $p=0.01$), systolic ($F=0.134$, $p=0.01$) and diastolic ($F=0.44$, $p=0.01$) blood pressure and waist circumference ($F=0.53$, $p=0.01$). Left ventricular hypertrophy (LVH) was the most common abnormality ($n=281$) and was positively associated with systolic ($F=0.12$, $p=0.01$) and diastolic blood pressure ($F=0.99$, $p=0.01$), and male gender ($X^2=60.5$, $p<0.01$). All ECG abnormalities (except for LVH) were associated with an increasing age, while right bundle branch block ($F=0.041$, $p=0.01$) and atrial fibrillation ($n=29$; $F=0.036$, $p=0.05$) were associated with the presence of diabetes mellitus ($n=211$). Only left bundle branch block ($n=50$) was associated with angina ($F=0.05$, $p=0.01$).

Conclusions Unrecognised cardiac abnormalities are common in middle-aged men and women with no overt symptoms. ECG offers the potential to identify these abnormalities and provide earlier intervention and treatment, and possibly improve cardiovascular outcome.

21 LATE DIAGNOSIS OF ABERRANT ORIGIN OF RIGHT PULMONARY ARTERY FROM ASCENDING AORTA AND INCREASED MORBIDITY

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Introduction The aberrant origin of a single pulmonary artery is a rare cardiovascular anomaly. So far 131 cases have been reported in English literature. It's a result of the failure of migration of embryonic branch of a pulmonary artery to reach the pulmonary trunk during embryological period. The aberrant origin of right pulmonary artery from ascending aorta (AORPA) can be associated with patent ductus arteriosus (PDA), atrial septal defect, ventricular septal defect and aortic arch isthmus hypoplasia, whereas, the aberrant left pulmonary artery is associated with the Tetralogy of Fallot. Early and rapid development of pulmonary hypertension is a hallmark of the underlying pathology in untreated cases and the one-year survival is approximately 30% in the absence of any surgical intervention. Hence, early diagnosis and surgical management is mandatory to optimise the outcome.

Subjects and methods We report a case of a 46 years old Caucasian female who presented with progressive breathlessness and productive cough and was investigated to delineate the presence of AORPA and its cardio-pulmonary associations with the help of a follow up CT scan, bronchoscopy and a cardiac MRI (CMR).

The patient had a surgical repair of PDA at the age of 3 and remained generally fit and well afterwards however, could never take part in the stamina sports and long distance running due to shortness of breath. In last decade, she had multiple episodes of recurrent respiratory tract infections and intermittent and relapsing allergic bronchopulmonary aspergillosis (ABPA). Her routine bloods showed eosinophilia and the lung function tests demonstrated a restrictive lung disease with FEV1 of 58% and vital capacity of 69% (predicted). She also had an asthma quality life questionnaire that scored 5.3. She had a HRCT chest seven years ago that showed right middle and lower lobe changes in line with the diagnosis of ABPA, AORPA with the signs of pulmonary hypertension, a slit like

Abstract 21 Figure 1 First row from left to right CXR – prominent hilar vessels; CT lung window – Infective changes; CT mediastinal window – Abnormal origin of right pulmonary artery from aorta with calcification; Cardiac MRI T1 image – dilated aorta and AORPA. Second Row from left to right 3D and MIP reformatting – showing this anomaly with right sided pulmonary hyperaemia; Bronchoscopy images – mucous secretions and bronchomalacia