

occult scaphoid fracture (sensitivity 92.1, specificity 48.4, LR-0.2 [95% CI 0.4–0.7]).

In conclusion, no single feature can satisfactorily exclude occult scaphoid fracture. However, a number of clinical findings significantly affect the pre-test likelihood of fracture. Future work should determine whether combinations of clinical findings can be used to guide which patients require immobilisation and further imaging despite normal initial radiographs.

1527

VENOUS THROMBOPROPHYLAXIS IN AMBULATORY EMERGENCY DEPARTMENT PATIENTS MANAGED WITH LOWER LIMB IMMOBILIZATION. A NATIONAL SURVEY

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Abstract 1527 Table 1 Responses to questions 3, 5, 7 and 9 of survey

Question 3. Would you consider thromboprophylaxis with the following? (116 responses)	Number (%)
Above knee Plaster of Paris or resin cast	114 (98)
Below knee Plaster of Paris or resin cast	110 (95)
Below knee Equinus Plaster of Paris or Resin Cast	110 (95)
Walking boot	61 (53)
Removable knee splint	23 (20)
No immobilisation, but crutches and weight bearing as tolerated	6 (5)
Question 5. What Risk Assessment Method do you use? (102 responses)	Number (%)
Locally developed tool (unpublished)	32 (31)
NICE guidelines	26 (25)
I do not know which one we use	23 (22)
GEMNet	7 (7)
Plymouth Score	7 (7)
L-TRIP(cast) Score	1 (1)
TRIP(cast) Score 3. Would you consider thromboprophylaxis with the following?	1 (1)
Modified Caprini Score	0 (0)
Other	6 (6)
Question 7. What Thromboprophylaxis agent is first line recommended at your institution? (112 responses)	Number (%)
Low Molecular Weight Heparin	78 (70)
Enoxaparin	42 (38)
Dalteparin	26 (23)
Tinzaparin	10 (9)
Direct Oral Anticoagulant	33 (29)
Rivaroxaban	27 (24)
Apixaban	6 (5)
Aspirin	1 (1)
Question 9. Which projects would your ED be willing to engage in? (109 responses)	Number (%)
A comparison of different Risk Assessment Models (RAMs)	66 (61)
A comparison of DOACs vs LMWH in all patients	66 (61)
A comparison of DOACs vs LMWH for selected patients at higher risk of VTE	55 (51)
An observational study of those not receiving VTE prophylaxis to determine modern event rates	46 (42)
A mixed methods study evaluating multiple objectives as above	45 (41)

Aims, Objectives and Background Approximately 2% of patients discharged from the Emergency Department (ED) in lower limb immobilisation after injury will develop symptomatic venous thromboembolism (VTE). Pharmacological thromboprophylaxis, in the form of low molecular weight heparin (LMWH) or fondaparinux can approximately halve this risk. However, it is not clear which patients would clinically benefit from this intervention, or if direct oral anticoagulants (DOACs) can be recommended for this indication. In the United Kingdom (UK), national guidance recommends patients be risk assessed to stratify thromboprophylaxis decisions. Consequently, various risk assessment methods (RAMs) have been evaluated but consensus is limited on the optimal approach.

Aim A national survey of UK practice in this clinical area to characterise variation and inform a recently commissioned research call.

Method and Design A 10-question electronic survey was created via the Smart Survey platform[®] and distributed to UK Type 1 EDs during February and March 2022. Duplicate ED responses were excluded and data analysed using Smart Survey Analytics.

Results and Conclusion A total of 116 (69%) of Type 1 EDs submitted a response. Nearly all (>95%) would consider thromboprophylaxis when a rigid cast was applied, but this was less for removable semi-rigid splints of the ankle (53%) or knee (20%). Of responding EDs, 83% used a RAM; most often a locally developed tool or NICE guidance. Published RAMs designed specifically for use in these patients were used by only 16% of EDs. When indicated, the majority of departments reported using LMWH (70%) in accordance with NICE guidelines, but 29% used a DOAC. Duration of thromboprophylaxis prescription also varied widely (table 1).

This national survey highlights considerable variation in all aspects of clinical practice regarding VTE prevention in patients managed with temporary lower limb immobilisation after injury. Over 60% of responding EDs expressed willingness and ability to participate in future research on this topic.

1704

FEASIBILITY OF IMPLEMENTING A 0–2 TROPONIN ALGORITHM IN ROUTINE CLINICAL PRACTICE

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Aims, Objectives and Background Recent guidelines for Acute Coronary Syndrome have recommended rapid diagnosis based on repeat sampling at 2 hours from admission. We investigated the feasibility and diagnostic equivalence of repeat measurement at 2 hours by comparing the diagnostic classification achieved by measurement at 0 and 2 hours with a delta value of ≤ 3 between samples to measurement at 0 and 3 hours and a delta of ≤ 7 ng/L between samples.

Abstract 1704 Table 1

Classification	Delta ≤ 3 at 2 h	Delta >3 at 2 h
Delta ≤ 7 at 3 hours	558	37
Delta >7 at 3 hours	6	35