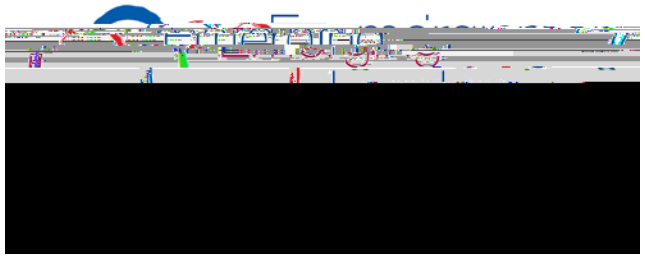
Disopyramide is recommended as second line therapy for symptomatic obstructive HCM in combination with beta blocker or verapamil prior to consideration of septal reduction therapy.[1,2] It is a class 1a antiarrhythmic medication but is now rarely used to control arrhythmias. It has marked negative inotropic properties which make it effective in reducing gradients created by outflow tract obstruction but it can have proarrhythmic properties and patients should be monitored for QT prolongation as a marker of risk for arrhythmia. Previous guidelines suggest that initiation should be performed in hospital with cardiac monitoring for serious adverse events (sustained atrial or ventricular arrhythmia, Torsade de Point) and regular QT interval assessment.[3] Updated guidelines make no recommendation regarding this and there are very few studies assessing the safety of outpatient initiation.[4,5]

Current practice in our Trust requires a 48-hour inpatient admission This is costly, limited by bed space which delays admission and impacts other services, and is an inconvenience to patients. Furthermore, the Covid-19 pandemic prevented such patients from receiving this treatment.



OBJECTIVES

We aimed to assess our own inpatient initiation service, t [(s)-5.5(ur)14(v)-22.4(ey)]TJ 3.712 0 Td [(w)-3.8(as)]TJ 2.542 0 Td [(s)-5.5(ent)]TJ -0.007 Tc 0.007 Tw 2.644 0 Td (to)Tj 0.003 Tc -0.003 Tw 1.576 0 Td [(c)-5.5(ar)-3(di)-12.3(ol)-12.2(og)-17.2(i)4.6(s)-