As per ESC: E-EPA $2 \times 2$ g per day should be considered in combination with a statin for patients with:

- Persistently high TGs ($1.5–5.6$ mmol/L)
- Treatment with a statin

**Results** 398 patients completed cardiac rehab during this study and were included in our database. Of these 275 (69%) had a 6 month TG and LDL recorded and were included. All patients in our cohort had been on a stable dose of statin for at least 4 weeks.

Analysis as per initial REDUCE IT protocol: 14/275 patients (5%) were excluded as they were less than 45 years old. 63 patients (23%) had a TG level of 1.5–5.6 and 42 of these had an LDL-C level of 1.06–2.59 mmol/L (15.3%). This led to an overall eligibility of 15.3% for E-EPA.

Analysis as per amended REDUCE-IT protocol: 14/275 patients (5%) were excluded as they were less than 45 years old. 30 patients had a TG level eligible as per the amended REDUCE-IT protocol (10.9%) and 20 of these patients had an LDL-C level of 1.06–2.59 mmol/L (7.3%) leading to an overall eligibility of 7.3% for E-EPA.

Analysis as per the ESC/EAS guidelines: Notably the ESC guidelines do not specify an LDL level or age required for E-EPA to be considered. 64 patients had a TG level of 1.5–5.6 mmol/L despite statin therapy. As such, 64/275 patients (23.3%) of our cohort would be eligible for E-EPA.

**Conclusions** E-EPA is a dominant cost-effective strategy to reduce CV risk in patients with elevated TG levels despite statin therapy.

Nearly one quarter (23.3%) of patients in our cohort would be eligible for E-EPA treatment in order to further reduce their CV risk.

Rehab services should develop screening strategies to identify and treat patients eligible for E-EPA therapy.

**56** **OPTIMISING LIPID TREATMENT FOLLOWING MYOCARDIAL INFARCTION**

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**Introduction** European Society of Cardiology (ESC) guidelines recommend intensive control of LDL cholesterol (LDL-C) following myocardial infarction (MI) to improve outcome. Early assessment of lipids post MI is confounded by acute phase response requiring re-testing to guide need for up-titrating ± additional treatment.

**Method** We studied patients admitted with MI across a healthcare region including 2 acute receiving hospitals over two years (2017–2018). Diagnosis, cardiovascular (CV) risk factors, CV history (Hx), lipid treatment before admission, lipid profile on admission, lipid treatment on discharge, lipid profiles at first and second follow up, changes to lipid treatment and readmission were recorded. Chi-squared was used to assess relationships between variables.

**Results** Of 638 acute MI admissions, 227(35.6%) had ST-elevation MI, 464(72.7%) were male, 174(27.3%) female. Baseline CV risk factors included diabetes 137(22.3%), family Hx 291(52.8%), smoking [current 188(30.9%); ex 164(26.9%)], CV Hx 359(58.1%). Lipid profile was tested on admission in 431(67.7%) subjects. For those already on lipid treatment, mean LDL-C was 2.22 mmol/l; for those not, mean was 2.91 mmol/l. Almost all (98.3%) were prescribed lipid lowering therapy prior to discharge (Atorvastatin 92.0%, Simvastatin 2.1%, Rosuvastatin 5.1%, Pravastatin 0.3%, Ezetimibe 0.5%). A high intensity statin was used in 94.4% of the sample.

Mean time to first follow-up lipid profile was 5.65 months. Follow up profiles were available in 85.6%, in whom mean LDL-C was 1.67 mmol/l. At first follow up 349(54.7%) met the 2018 ESC target <1.8 mmol/l. For those not at target, 62 (32.8%) received no further lipid testing and 13(6.9%) had therapy increased. At final lipid test, 62.7% achieved LDL-C <1.8 mmol/l. Males (p≤0.1) and diabetics (p = 0.01) were more likely to achieve target. Females were more likely to receive a lower dose of Atorvastatin (p = 0.004). There was no significant relationship between diabetes and discharge on