(2019) and major adverse cardiovascular events (MACE) reviewed with a mean follow up time of 3.8 years.

**Results** A total of 1221 cases were reviewed between March 2015 and November 2018. 73 patients were excluded where they were referred on for further cardiologist assessment (54) or where insufficient data was available (19). Of the remaining 1148, 44 patients (1% per year) went on to be diagnosed with coronary artery disease, 26 of which had no prior history of IHD. 25 patients presented as an emergency with acute coronary syndrome. We observed a total of 19 deaths (0.44% per year) that could have been attributable to cardiac disease however our follow up is limited to locally available data. 38 patients were re-referred for investigation of chest pain; 33 of which had normal investigations and 5 patients were reassured and discharged again without investigation. Only 43% of patients seen and discharged without investigation had a low risk pre-test probability score of <5% with 21% having a high pre-test probability score. Whilst the majority of adverse events were seen in those with intermediate and high pre-test probabilities, overall adverse event rate remained low over a long follow up period.

**Conclusion** Whilst a pre-test probability score may help to determine which patients are more likely to go onto develop coronary disease, the majority of patients discharged with non-anginal pain were in the intermediate and high risk groups. We recognise that clinical suspicion of coronary disease is an important part of the decision making process and that this model relies on the clinical skill of the specialist nurses in RACP clinics. We have demonstrated that where chest pain is non-anginal in character, patients can be safely reassured and discharged without investigation with a low adverse event rate over a long follow up period.

**Conflict of Interest** None

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**Patients Presenting With Acute Coronary Syndromes Have Unreported Coronary Artery Calcium On Historical CT Imaging**

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**Introduction** Ischaemic heart disease (IHD) remains the leading cause of mortality globally.1 The presence and extent of coronary artery calcification (CAC) is a strong predictor of cardiovascular events, and CAC scoring has been shown to be more predictive of cardiovascular events than other traditional risk assessment scores.2 Incidental coronary calcification can be detected and quantified on non-gated CT chest scans covering the heart in the field of view.3 This finding is typically not reported4 and hence an opportunity to optimise cardiovascular risk assessment and treatment is missed. The Society of Thoracic Radiology have previously highlighted that incidental coronary calcification should be reported on CT chest scans.5 We sought to investigate patients presenting to our centre with an acute coronary syndrome (ACS) event with historical CT imaging demonstrating coronary artery calcification.

**Methods** We retrospectively reviewed case records for all patients referred to our centre for an invasive coronary angiogram following their first known admission with an ACS event. ACS were defined according to contemporary guidelines from the European Society of Cardiology. We reviewed a 3 month period prior to the COVID-19 pandemic (01/01/2019 - 31/03/2019). The national imaging database in Scotland (PACS) was interrogated to identify previous CT imaging that includes the heart in the field of view. The presence of coronary calcification was confirmed and quantified using an ordinal scoring method previously described. The clinical radiology reports for the scans were reviewed to determine the frequency of CAC being reported. Demographic information was collected from our electronic patient record (Clinical Portal) including the presence of risk factors for IHD. Prescribed medication prior to admission was also recorded using the on-admission medicines reconciliation documented in the electronic patient record.

**Results** 385 patients with first presentation of ACS were identified (figure 1). 75 (19%) had a prior non-gated CT chest imaging. The most common indication for CT was for investigation of possible malignancy. The mean interval from CT imaging to ACS admission was 36 months. CAC was present on 67 (89%) scans. The mean ordinal score was 4.04, corresponding to moderate CAC. The distribution of CAC by coronary artery revealed the majority of disease to involve the left anterior descending artery (table 1). Only 12/67 (18%) of

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clinical radiology reports mentioned coronary calcification (figure 2). Patients with CAC frequently had risk factors for IHD (table 2). Despite this only 42% were prescribed antiplatelet therapy, and only 45% prescribed a statin.

Conclusions A significant proportion of ACS admissions have evidence of CAC on historical CT scans. This finding is often not reported and the majority of patients with demonstrated coronary artery disease are not prescribed appropriate preventative therapies. Systematic reporting of this finding may have a significant impact on the prevention of acute cardiovascular events.

Conflict of Interest None

INTRODUCTION OF A MULTIDISCIPLINARY CARDIAC METABOLIC CLINIC IN A UK TERTIARY CARDIOLOGY CENTRE: EARLY ACTIVITY, INTERVENTIONS AND POTENTIAL FOR CARDIOVASCULAR RISK OPTIMISATION

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Introduction Diabetes mellitus (DM) is associated with a doubled risk of adverse cardiovascular (CV) outcomes and a 2.5x risk of heart failure (HF) (1,2). The potential to improve clinical outcomes in patients with DM and cardiovascular (CV) disease have been augmented by evidence from CV outcome trials of sodium-glucose cotransporter 2 inhibitors (SGLT2) and glucagon-like peptide 1 receptor agonists (GLP-1) demonstrating significant reduction in major adverse CV events (MACE) and with SGLT2i, significantly reduction in HF-related hospitalization. (3) Given this evidence there is a need for specialist clinicians to assist in overcoming clinical inertia in their implementation to improve patient care and prognosis. (3)

Purpose To review the initial activity and clinical interventions resulting from an innovative cardiometabolic clinic (CMC) service within an NHS tertiary cardiac centre, incorporating a consultant diabetologist and cardiologist, in which patients’ concomitant CV and metabolic risk are addressed simultaneously.

Methods Patient data (biochemistry, radiology results and observations including weight, symptoms, blood pressure, blood glucose) and clinic activity (consultation notes and GP correspondence) were reviewed retrospectively over a 6 month period from 29/09/2020 to 29/03/2021.

Results A total of 144 patients have been referred to CMC, of which 64 were seen during the study period, 6 did not attend, and 74 await an appointment. Of the 64 seen, 13 have been discharged back to the referrer and/or to a more appropriate clinician. Referrals to other specialists have been made for 26 patients to augment their care. Initiation of SGLT2 and GLP-1 was recommended for 31 and 9 patients, respectively. Up-titration of existing SGLT2i and GLP-1 was carried out for two patients already on each of these agents. Additionally, 28 other medications were initiated or optimised (5 diuretics, 3 antihypertensives, 3 lipid-lowering therapies, 2 beta blockers, 1 angiotensin-receptor blocker, 1 anticoagulant, 2 orlistat, 8 metformin and 3 other anti-diabetics). Medications for 12 patients were stopped due to contraindication, intolerance or to permit introduction of evidence-based therapy. Each consultation has also included discussion of lifestyle interventions as per latest ESC guidelines. Among the 32 patients in whom antidiabetic drugs (including SGLT2, GLP-1) have been initiated or titrated, one available marker of clinical effect associated with these interventions has been glycaemic control as quantified by HbA1c. Reduction in HbA1c has been observed in 11 patients (mean reduction 17.7 mmol/mol), while 3 have noted an increase