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

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**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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**Abstract 197**

**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 oral statins, 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 anti-diabetic 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.
(mean 4.7 mmol/mol, and results are pending for 18 patients. Collection of outcomes including hospitalisations for HF, CV events, ejection fraction, and adverse effects of treatment is ongoing. The above has been achieved despite limitations imposed by the remote nature of the clinic due to the Covid-19 pandemic, which limits performance of blood tests, echocardiograms and observations. This limitation is expected to be ameliorated by conducting in-person clinics in future.

**Conclusions**

Operation of a joint CMC facilitates optimisation of the pharmacological management of risk factors in patients with cardiac and metabolic disease, particularly incorporation of current evidence-based therapies. Emerging outcomes indicate the potential impact of this service on patients’ long term CV outcomes.

**Conflict of Interest**

Nil

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### PRIMARY CARE USE OF SGLT2 INHIBITORS IN PATIENTS WITH TYPE 2 DIABETES MELLITUS AND CARDIOVASCULAR DISEASE – ARE WE MISSING A TRICK?

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**Background**

Patients with Type 2 Diabetes Mellitus (T2DM) and Atherosclerotic Cardiovascular Disease (ASCVD) have an average reduction of 12 years in life expectancy. The landmark EMPA-REG trial in 2013 demonstrated that SGLT2i significantly reduced risk of all-cause mortality in this population of patients. The NNT was 39 at 3.1 years. This is comparable to other landmark studies such as the 4S study (Simvastatin NNT 30 at 5.3 years) and the HOPE trial (Ramipril, NNT 50 at 5 years). International guidelines recognise the CV benefits of SGLT2i. They suggest SGLT2i should be used as a second line therapy or as a first line intervention in treatment naïve T2DM patients who have ASCVD.

**Objectives**

To assess use of SGLT2i in patients with T2DM and known ASCVD in primary care. Additionally, to understand the potential benefit of introducing SGLT2i to these patients in primary care.

**Methods**

The patient list of a GP surgery was searched for patients coded to have T2DM and ASCVD. Demographics, most recent HbA1c and eGFR, diabetic and cardiology medication were recorded. Search criteria were as follows: Myocardial Infarction, Unstable Angina, Ischaemic Stroke, Haemorrhagic Stroke, Peripheral Artery Disease, AAA,

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![Patients on medication with CV benefit](image)

**Abstract 198 Figure 1**

![Use of Diabetic Medication in Patients with T2DM and ASCVD](image)

**Abstract 198 Figure 2**