Of 293 patients admitted with acute MI, 108 (36.8%) had STEMI and 185 (63.2%) non-ST elevation MI or unstable angina. Gender split was approximately 2:1 male:female. Baseline CV risk factors included family history 63%

Results Lipid treatment during follow up were recorded. Of the inappropriate turned downs 6 were re-referred and had pPCI to a culprit coronary artery and 1 had Takotsubo syndrome. From the accepted cohort, 114 (85%) had pPCI to a culprit coronary artery and 20 (15%) had no intervention (3 Takotsubo syndrome, 1 coronary spasm, 4 pericarditis, 3 chronic total occlusion of coronary artery, 8 non-obstructive coronary artery disease and 1 stroke). In the appropriately turned down cohort, the final diagnosis was cardiac in 127 (53%) patients, non-cardiac chest pain in 25 (11%), miscellaneous in 67 (29%) and COVID-19 in 16 (7%) [table 2]. One-year mortality rate of the turned down cohort was 16% (38/235) of which 55% (21/38) was in the cohort with a final cardiac diagnosis, 13% (5/38) was due to COVID-19 and the remaining 32% (12/38) from the miscellaneous cohort [table 1 and 2]. In 2020 there was a 29% (130 vs 182) reduction in the number of pPCIs performed in the 3 months from March to May in comparison with the previous year [figure 2].

Conclusions During the first wave of COVID-19 there was a significant reduction in the number of pPCIs performed. This was not due to an increase in inappropriate turn down of referrals. No patient was turned down because of COVID-19. Of the turned down patients the majority (53%) had a final cardiac diagnosis. One year mortality in this group was significant.

ESC guidelines recommend a target LDL cholesterol (LDL-C) of <1.8mmol/l following myocardial infarction (MI). Early assessment of lipids post MI is confounded by acute phase response requiring convalescent re-testing to guide need or otherwise for up-titration ±additional treatment.

Methods We studied consecutive patients admitted with acute myocardial infarction over one year (April 2016 – April 2017). Baseline diagnosis, cardiovascular (CV) risk factors, CV history, lipid treatment before admission (if any), lipid levels pre or within 24 hours of admission, lipid treatment on discharge, lipid levels at >3 months follow up, and changes to lipid treatment during follow up were recorded.

Results Of 293 patients admitted with acute MI, 108 (36.8%) had ST elevation MI and 185 (63.2%) non-ST elevation MI or unstable angina. Gender split was approximately 2:1 male:female. Baseline CV risk factors included family history 63%
META-ANALYSIS OF RANDOMISED CONTROLLED TRIALS INVESTIGATING THE IMPACT OF COLCHICINE ON MAJOR ADVERSE CARDIOVASCULAR EVENTS IN ACUTE CORONARY SYNDROME

Introduction Colchicine has been shown to reduce inflammation and has a potential to stabilise atherosclerotic plaques. Clinical studies have suggested a role for colchicine in reducing adverse cardiovascular events in patients with coronary artery disease. The aim of the present meta-analysis was to investigate the effect of colchicine on outcomes following coronary intervention among patients presenting with acute coronary syndrome (ACS).

Methods We searched for randomised controlled trials (RCTs) comparing colchicine to placebo in patients with ACS undergoing coronary intervention using the initial MESH terms ‘colchicine’ and ‘cardiovascular system’. Eligible RCTs published up to November 2020 were included. We also searched presentations from the proceedings of relevant international scientific meetings. The primary endpoint was major adverse cardiovascular events (MACE). Study level odds ratios (ORs) and 95% confidence intervals (CI) of MACE were pooled using the Mantel-Haenszel method and random effects model. Forest plots were generated using Review Manager (RevMan) 5.4 software.

Results Our initial search identified 1,049 articles for potential inclusion. Of these studies, 4 RCTs were found to be eligible: COPS, COLCHICINE-PCI, COLCOT time-to-Initiation (TTI) 0-3 days and PODCAST-PCI. Overall a total of 2,709 patients were randomly allocated to treatment with either colchicine (n=1,367) or placebo (n=1,342). Patients received colchicine either prior to angiography or within 3 days post-procedure. Follow up duration ranged from 30 days to 3 years. Mean age of the whole analysed cohort was 60.3±10.5 years; 73% were male; 51% had a history of hypertension, 26% had diabetes mellitus, 38% were current smokers. There were 89 events in the colchicine group as opposed to 133 events in the placebo group. The risk of MACE was lower in patients treated with colchicine as compared with placebo (OR 0.63, 95% CI 0.48-0.84, p=0.001) (see figure 1). Heterogeneity across trials was not detectable (I²=0).

Conclusions The results of our meta-analysis suggest that among patients presenting with acute coronary syndrome undergoing coronary intervention, treatment with colchicine instead of placebo reduces the risk of MACE. Further investigations in larger cohorts are warranted to test this effect.

48 IDENTIFICATION OF NOVEL PROTEIN BIOMARKERS FOR ATRIAL FIBRILLATION

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BACKGROUND Cardiac rehabilitation (CR) programs provide an opportunity to measure low density lipoprotein cholesterol (LDL-C) levels and optimise lipid lowering therapy (LLT) accordingly. New ESC guidelines released in August 2019...