PROTOCOL TITLE:

Prospective Randomized Trial of Emergency Cardiac CT: (PROTECCT Trial)

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v1.13-03.10.2018
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REC reference number: 17/EM/0375; IRAS Project ID: 223704
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### Glossary of Terms and Abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ACP</td>
<td>Acute Chest Pain</td>
</tr>
<tr>
<td>AMI</td>
<td>Acute Myocardial Infarction</td>
</tr>
<tr>
<td>ACS</td>
<td>Acute Coronary Syndrome</td>
</tr>
<tr>
<td>CAD</td>
<td>Coronary Artery Disease</td>
</tr>
<tr>
<td>CD</td>
<td>Compact Disc</td>
</tr>
<tr>
<td>CTCA</td>
<td>Computed Tomography Coronary Angiography</td>
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<tr>
<td>cTn</td>
<td>Cardiac Troponin</td>
</tr>
<tr>
<td>ECG</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>ESC</td>
<td>European Society of Cardiology</td>
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<tr>
<td>FFR</td>
<td>Fractional flow reserve</td>
</tr>
<tr>
<td>GSTFT</td>
<td>Guy’s and St. Thomas’ NHS Foundation Trust</td>
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<tr>
<td>GTN</td>
<td>Glyceryl trinitrate</td>
</tr>
<tr>
<td>HU</td>
<td>Hounsfield Unit</td>
</tr>
<tr>
<td>hs-cTn</td>
<td>High-sensitivity cardiac troponin</td>
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<tr>
<td>ICA</td>
<td>Invasive Coronary Angiogram</td>
</tr>
<tr>
<td>IVUS</td>
<td>Intra-vascular ultrasound</td>
</tr>
<tr>
<td>LAD</td>
<td>Left Anterior Descending</td>
</tr>
<tr>
<td>LM</td>
<td>Left Main</td>
</tr>
<tr>
<td>MACE</td>
<td>Major Adverse Cardiac Events</td>
</tr>
<tr>
<td>NPV</td>
<td>Negative Predictive Value</td>
</tr>
<tr>
<td>OCT</td>
<td>Optical coherence tomography</td>
</tr>
<tr>
<td>OP</td>
<td>Out-Patient</td>
</tr>
<tr>
<td>OPD</td>
<td>Out-Patient Department</td>
</tr>
<tr>
<td>PCI</td>
<td>Percutaneous Coronary Intervention</td>
</tr>
<tr>
<td>PPV</td>
<td>Positive Predictive Value</td>
</tr>
<tr>
<td>SCCT</td>
<td>Society of Cardiovascular Computed Tomography</td>
</tr>
<tr>
<td>TCFA</td>
<td>Thin Capped Fibroatheroma</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</tbody>
</table>

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1. Background and Pilot Data

Coronary artery disease (CAD) remains the most common cause of mortality in the world according to the World Health Organization (WHO). Chest pain accounts for a significant healthcare burden representing approximately 700,000 annual visits to the emergency department in England and Wales [1]. Patients with acute chest pain (ACP) suggestive of a cardiac aetiology account for approximately 17% of all emergency department (ED) consultations, but less than 10% of these are eventually diagnosed as having acute myocardial infarction (AMI). On the other hand, the most common reason for patients with a missed diagnosis of AMI has been shown to be non-cardiac chest pain and the discharge of these patients may be associated with increased mortality [2].

Hence a means of evaluating these patients in the emergency department in an efficient manner, whilst ensuring high sensitivity and specificity, is of paramount importance. Cardiac biomarkers e.g. cardiac Troponin (cTn) I or T along with electrocardiogram (ECG) remain the cornerstone in the evaluation of patients with suspected acute coronary syndrome (ACS).

Former generation conventional cardiac troponin (cTn) assays were limited by their inability to detect low levels of cTn. This, coupled with the delayed increase of circulating levels of cTn, meant low sensitivity at the time of a patient’s presentation and this would result in the requirement of serial cTn testing for up to 6 hours [3]. The consequent delay in confirming a diagnosis of ACS would potentially lead to complications due to delays in treatment, and delays in excluding the diagnosis would lead to overcrowding in the emergency department and increased cost to the healthcare system.

1.1 Performance of high-sensitivity cardiac troponins

In an effort to address the aforementioned issues with conventional cTn’s, high-sensitivity cardiac troponin (hs-cTn) assays have been developed. These assays enable the measurement of cTn at concentrations not detected with the former generation conventional cTn assays. In September 2015 hs-cTn assays were adopted in the
European Society of Cardiology (ESC) guidelines for the management of patients with acute coronary syndrome (ACS) without persistent ST elevation. The proposed algorithms advocate either a single hs-cTn at ED presentation or repeat measurements after 1 or 3 hours and thus enable a more rapid “rule-in” and “rule out” of AMI compared with conventional cTn assays. The cut off values for the different hs-cTn assays are assay specific [4].

The ESC guidelines proposed ‘hs-cTnT guided algorithm’ assigns “rule out” status to patients with an hs-cTnT level below 5ng/L (the limit of detection for the assay) at presentation or between 5 and 11 ng/L on initial testing and Δ1 hour of below 3 ng/L. A “rule in” status is assigned to patients with an initial hs-cTnT value of at least 52ng/L or a Δ1 hour of at least 5ng/L on serial testing. The remaining patients would remain in an observational zone (Figure 1.).
Figure 1.

*Step 2 (a)

0 hour 5-11ng/L

- Δ1 hour of <3ng/L: Low Risk, Rule out MI
- Δ1 hour of 3-4ng/L: Observational zone
- Δ1 hour of ≥5ng/L: High Risk, Rule in MI

*Step 2 (b)

0 hour 12-51ng/L

- Δ1 hour of <5ng/L: Observational zone
- Δ1 hour of ≥5ng/L: High Risk, Rule in MI

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The performance of these algorithms (involving hs-cTn) has been evaluated in multiple studies. Ruling out AMI based on undetectable levels of hs-cTn at presentation has been shown to be very safe with high negative predictive values. A prospective multicenter study by Gimenez et al looked at ruling out AMI using undetectable levels of hs-cTn (I and T) at presentation. With hs-cTnT, AMI was ruled out in 26.5% of cases with a sensitivity of 98.2% and negative predictive value (NPV) of 98.6%. Among three different hs-cTnI assays which were studied, the NPV ranged from 98.8% to 100%. No patient with undetectable levels of hs-cTnT died during the first 30 days and only 0.4% had died (2 patients not due to AMI) at 24 months’ follow-up. Among the three hsc-TnI assays, mortality at 24 months’ follow-up ranged from 0 to 2.4% with only one death due to AMI (which occurred in the first 30 days). In contrast, mortality was significantly higher among patients with detectable levels of hs-cTn [5].

Although the more rapid risk-stratification with these algorithms (on the first sample of hs-cTn) helps in reduced time to rule-in or rule-out AMI there remains, however, (between the initial “rule-in” and “rule-out” categories) an intermediate “observational zone” category of patients, who do require a serial troponin test at 1 hour for further risk-stratification. With the adoption of these ACS management algorithms, pilot data by Marjot et al have shown that, after initial hs-cTnT testing on presentation, there are a significant proportion of patients (54%) who would require further troponin testing after 1 hour as they were stratified in an intermediate category (neither rule in nor rule out) on the initial troponin test. Despite the mandated repeated troponin at 1 hour, Marjot et al also showed that in real world practice, the mean time to repeat troponin was still 2.9 hours and that after training and implementation of the algorithm for 3 months, over 65% of patients still had their troponin taken at least 90 minutes after the first [6]. Similarly, in a sub-study of the ROMICAT II trial, Ferencik et al also found that a substantial 86.9% of patients had intermediate hs-cTn levels on initial testing and the addition of a second or third hs-cTn level did not improve risk stratification [7]. A study involving hs-cTnI (in a 2-hour algorithm) by Lindahl et al showed that, after having ruled out / ruled in AMI based on a 1st troponin test on presentation, 47.1% remained in the observational zone. After a repeat troponin 2 hours later, 25.5% of patients, still remained in the observational zone [8]. This
presents an opportunity for a possible alternative means of further evaluating the initial intermediate category cohort of patients in a more efficient manner.

Other studies that have investigated/validated the approach involving a repeat hs-cTn at 1 to 2 hours to rule-in or rule-out have also shown high sensitivities and NPV’s (see table 1).

<table>
<thead>
<tr>
<th>Author</th>
<th>HsC-Tn assay type/Time to repeat</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>PPV</th>
<th>NPV</th>
<th>Mortality in “rule-out” group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lindahl et al [8] (2016)</td>
<td>HsC-TnI (2 hours)</td>
<td>97.7%</td>
<td>95.2%</td>
<td>74.5%</td>
<td>99.4%</td>
<td>0% at 30 days</td>
</tr>
<tr>
<td>Jaeger et al [9] (2016)</td>
<td>HsC-TnI (1 hour)</td>
<td>100%</td>
<td>96%</td>
<td>70%</td>
<td>100%</td>
<td>1.7% at 360 days</td>
</tr>
<tr>
<td>Mueller et al [10] (2015)</td>
<td>HsC-TnT (1 hour)</td>
<td>96.7%</td>
<td>96.1%</td>
<td>77.2%</td>
<td>99.1%</td>
<td>0.7% at 365 days</td>
</tr>
<tr>
<td>Reichlin et al [11] (2015)</td>
<td>HsC-TnT (1 hour)</td>
<td>99.6%</td>
<td>95.7%</td>
<td>78.2%</td>
<td>99.9%</td>
<td>0% at 30 days</td>
</tr>
</tbody>
</table>

Table 1.

However as is evident in Table 1, the excellent negative predictive value to rule-out AMI comes at a cost of a modest reduction in the positive predictive value to rule-in AMI. This is contributed to by the ability of hs-cTn’s to detect concentrations at <99th percentile for at least 50-95% of healthy individuals and due to possible other causes of elevated troponin e.g. renal dysfunction, tachy- and brady-arrhythmias, pulmonary embolism etc.

Furthermore, multiple aforementioned studies (Table 1) also showed that, even after repeat serial 1-hour troponin, a significant proportion of patients remain in the intermediate “observational zone” category and this is associated with mortality and
adverse cardiac event risks. Suggestions for further management of these patients is not standardized and in fact is very individualized and guided by possible further repeat troponin and/or invasive or non-invasive cardiac imaging [4]. In a recent prospective international multicenter trial, Mueller et al found that 22.5% of patients remained in the observational zone and cumulative mortality for this cohort was 0.7% at 30 days but increased substantially to 9.6% at 365 days. This was in comparison to “rule out” and “rule in” mortalities of 0.1 and 2.7% at 30 days and 0.7% and 8.9% respectively at 365 days. An adjudicated diagnosis of acute myocardial infarction (AMI) was found in 22.5% of patients in the observational zone [10]. Similarly, in an international multicenter validation study of the 1-hour troponin algorithm, Reichlin et al found that 24.1% of patients were found to be in the observational zone. In this cohort, the prevalence of acute MI was 18.6% and the cumulative mortality was 1.6% at 30 days, rising to 16.5% at 2 years’ follow-up (versus cumulative mortality of 1.1% and 13.4% for rule-in and rule-out categories at 2 years) [11]. Mokhtari et al evaluated major adverse cardiac events (MACE) at 30 days in a prospective observational study where the 1-hour hs-cTnT algorithm supplemented by patient history and ECG (“extended algorithm”) was compared with an algorithm using hs-cTnT alone (troponin algorithm). Despite the addition of patient history and ECG, the proportion of patients remaining in the observation zone was not significantly different between the two algorithms and was found to be of the order of 25-27%. In the extended algorithm, the 30-day MACE event rate including unstable angina was 10.1% in the observational zone cohort versus 0.5% for “rule out” and 62.3% for “rule in” [12]. The aforementioned study by Jaeger et al (involving a similar 0/1hour algorithm using hs-cTnI) showed that 33% of patients remained in the observational zone and the cumulative mortality was found to be 0.6% at 30 days and 3.55 at 360 days [9]. These studies aptly demonstrate the presence of a significant cohort of patients who remain in the observational zone despite the use of the most up to date and sensitive means available to safely rule-out and rule in AMI with the use of serial hs-cTn’s. Thus, again there is a pressing need to clarify risk stratification and further clinical management in order to reduce the proportion of patients who end up languishing in the observational zone.
1.2 Possible role for computed tomography coronary angiography

The use of computed tomography coronary angiography (CTCA) in patients with acute chest pain has been shown to be safe [13], with high sensitivity and negative predictive value for coronary artery disease [14-17] and cost-effective with decreased time to diagnosis and earlier discharge from the emergency department [13, 18]. The finding of coronary artery disease on CTCA has been shown to predict prognosis, with significantly worse MACE for patients with obstructive stenosis (>50%), compared to those with results ranging from normal coronaries to non-obstructive stenosis (<50%) (Figure 2) [19-21]. The ACRIN-PA study by Litt et al, found that none of the patients who were discharged (after having been found to have <50% stenosis on CTCA) had AMI or death at 30 days’ follow-up [22]. In the CT-STAT trial, patients in the CTCA arm who had <25% stenosis were discharged and authors noted that no patients died or had late ACS at 6 months’ follow-up [18]. In the observational ROMICAT I trial, absence of significant CAD (defined as >50% stenosis) had a NPV of 98% for ACS and 100% when CTCA showed no plaque disease. However, sensitivity for ACS was 77% when using <50% stenosis cut off, as 7 patients with <50% stenosis had ACS [17]. Historically 10% of patients with clinical Non-ST-elevation myocardial infarction (NSTEMI) on conventional troponin analysis were found to have unobstructed (<50% stenosis) coronary arteries on invasive coronary angiography. Subsequently it has been shown that approximately only 10% of these patients have actual evidence of subendocardial infarction when investigated on late-gadolinium enhanced cardiac MRI (CMR) [23]. Hence in our proposed research clinical pathway (detailed in section Experimental details and design of proposed investigation), we have selected the conservative value of <25% stenosis to rule out AMI.
Figure 2. (Source: Hulten et al [21])

The above studies involving CTCA in patients with acute chest pain demonstrate that the main strength of CTCA lies in its ability to more rapidly and safely rule out coronary artery disease (and thus ACS) compared with conventional acute chest pain algorithms involving the use of slow release troponin assays. In more recent times, the ability of hs-cTn’s to more rapidly “rule in” or “rule out” ACS with one blood test has obviated the previous need for prolonged observation with serial troponin testing. However as stated previously, a significant number of patients still remain in the intermediate observational zone after both first and second serial hs-cTn. Also of importance is the fact that despite mandating a repeat serial second hs-cTn at 1 hour post initial troponin, in real world practice, it can take at least 90 minutes for the serial blood test to take place [6]. Modern day CTCA procedural time makes it a feasible investigation modality to be carried out during the time the patient is waiting to have their serial second hs-cTn taken.

Thus far, very few studies have examined the possible role of CTCA in the era of hs-cTn’s. The aforementioned observational sub-study of the ROMICAT II trial by Ferencik et al, showed that CTCA, with advanced plaque assessment, significantly decreased the proportion of patients who had been classified in the intermediate category on initial hs-cTn from 43.8% to 24.4%. The study concluded that CTCA, with high-risk plaque assessment following hs-cTn, led to improvements in diagnostic

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accuracy of patients with suspected ACS, compared with conventional slow release troponin and traditional CTCA assessment (based on luminal stenosis alone). However, drawbacks of the study included the observational design and the unlimited time for CT interpretation. Thus, one can call into question whether advanced plaque features could be assessed in the real world setting of a busy emergency department to make rapid decisions regarding admission or discharge [7].

The prospective randomized BEACON study compared the use of CTCA in addition to hs-cTn with a conventional management strategy involving hs-cTn alone. The authors concluded that the CTCA supplemented strategy did not meet the primary endpoint of identifying more patients with significant CAD requiring revascularization. In contrast to previous studies, the use of CTCA also did not shorten hospital stay nor allow for more direct discharge from the emergency department, despite 48% of patients having no identifiable CAD and serial troponin testing being carried out at 3-6 hours. The main benefits of CTCA included significantly lower direct medical costs and less out-patient testing. However, duration of hospital stay was not the primary endpoint and the exclusion criteria did not include a specified lower limit for hs-cTn for ruling out AMI [24]. Given the drawbacks of these studies, there is potential for further research with regard to the role of CTCA in the era of hs-cTn’s in a prospective randomized manner, in order to clarify how it may influence hospital length of stay as the primary endpoint.

Therefore, in acute chest pain patients, there is a compelling need to compare the performance of a management strategy involving hs-cTn supplemented by CTCA in a direct prospective randomised fashion, with usual standard of care involving serial hs-cTn alone, in the cohort of patients deemed to be in the intermediate observational zone according to the initial hs-cTn result. This is to determine its effect on hospital length of stay as the primary endpoint and also to determine safety, further risk category, aid in clinical decision making, and to evaluate for clinical outcomes.

1.3 FFR-CT

Fractional flow reserve (FFR), measured with aid of an intracoronary pressure wire under maximal hyperemia during invasive coronary angiography, is the gold standard in terms of identifying lesion specific ischemia. An FFR value of 0.80 or less (i.e. a
drop in maximal blood flow of 20% or more caused by a coronary stenosis) indicates the potential of the stenosis to induce myocardial ischemia. Optimal medical therapy, along with percutaneous coronary intervention (PCI) guided by objective evidence of ischemia, in patients with stable coronary artery disease, has been shown to have better outcomes compared with optimal medical therapy alone in two important trials: COURAGE nuclear sub-study and FAME II, which employed the use of invasive FFR [25, 26].

Fractional flow reserve derived from CT (FFR-CT) is one of the latest developments in coronary assessment by CTCA to identify hemodynamically significant coronary stenoses. FFR-CT measurements are calculated using computer software, which combines mathematical calculations involving computational fluid dynamics and an anatomical model of the coronary arteries, derived from CTCA. It can be calculated at each point in the coronary tree under simulated maximal hyperemic conditions without the need for additional image acquisition/ionizing radiation or medication. A number of studies have evaluated the performance of FFR-CT. In the DISCOVER-FLOW trial involving 103 patients, the investigators found that on a per-vessel basis, the sensitivity, specificity, positive predictive value, and negative predictive value were 87.9%, 82.2%, 73.9% and 92.2% respectively, when compared with the reference standard of invasive FFR [27]. Also, in the landmark multicenter NXT trial involving 254 patients, (using invasive FFR as the reference standard), the addition of FFR-CT to traditional CTCA assessment was shown to improve diagnostic accuracy and specificity for the detection of ischemia, and therefore hemodynamically significant CAD on both per-patient and per-vessel basis when compared with CTCA stenosis assessment alone. In this trial, 93% of patients had intermediate (30-70%) stenoses and the investigators found that the per-vessel sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) of FFR-CT (84%, 86%, 61% and 95% respectively) were improved compared with that of CTCA alone (83%, 60%, 33% and 92% respectively) [28]. A sub-study of the NXT trial by Norgaard et al further showed that FFR-CT provided high diagnostic performance compared with standard CTCA assessment even in high coronary calcium score quartiles (121 to 1703 Agatston units) [29]. In the landmark PLATFORM trial, investigators showed that FFR-CT worked as an effective gatekeeper for patients intended for invasive coronary angiography (ICA), with significantly fewer rates of
no obstructive CAD found on ICA when selection was guided by FFR-CT (73.3% in the ICA arm and only 12.4% in the FFR-CT guided arm). This resulted in the cancellation of 61% of ICA’s and none of these patients had adverse clinical events. It also showed that there was no statistically significant difference in the finding of no obstructive CAD found on ICA when selection was guided by FFR-CT or usual non-invasive testing e.g. stress testing (including stress echo, nuclear myocardial perfusion, CTCA etc.). It would have been interesting to see the performance of FFR-CT/CTCA against stress testing alone in the non-invasive arm. The inclusion of CTCA (with its high negative predictive value for CAD) in 60% of cases may have improved the rate of the primary end-point in the non-invasive testing arm [30]. Indeed, the PROMISE trial showed that anatomic testing with CTCA was associated with significantly fewer catheterizations showing no obstructive CAD compared to functional stress testing [31]. The FFR-CT RIPCORD study by Curzen et al showed that after disclosure of FFR-CT data there was a change in the allocated management strategy on the basis of CTCA alone in a substantial 36% of cases [32].

However, it is important to note that, to date, the above-mentioned studies involving FFR-CT have been carried out in stable chest pain populations and its evaluation in the acute chest pain patients who have corresponding hs-cTn results remains yet to be investigated.

2. **Study Objectives and Design**

2.1 Aim of the study

In patients with ACP requiring serial hs-cTn testing, to perform a head-to-head comparison of a management strategy involving serial hs-cTn supplemented by CTCA versus the conventional standard of care management guided by serial second hs-cTn alone in a randomized prospective trial. To the best of the author’s knowledge this study will provide the first prospective and randomized data in the use and outcomes of CTCA on this ACP cohort (with an intermediate observational zone category on initial hs-cTn) results presenting to the emergency department in a tertiary hospital (see Study 1 below).
It will also provide further data on the influence of more advanced CTCA diagnostics (e.g. FFR-CT, advanced plaque characterization) in clinical decision making, incremental to that provided by hs-cTn based care alone in patients with acute chest pain (see Study 2 below).

2.2 Original hypothesis
The use of CTCA will lead to improvements in hospital length of stay and risk stratification and clinical management of patients in the intermediate/observational zone category on initial hs-cTn when compared with standard of care involving serial hs-cTn alone.

2.3 Experimental Details and Design of the Proposed Investigation
The proposed work is divided into two clinical studies:

**Study 1:** Prospective, randomized single-center trial to compare hospital length of stay, patient clinical management and outcomes between standard of care supplemented by CTCA versus standard of care alone, in ACP patients deemed to be in the intermediate observational zone category on initial hs-cTn in an acute hospital setting.

An unselected cohort of adult patients who attend the Accident and Emergency Department of St. Thomas’ Hospital with acute chest pain, who have been found to be in the intermediate observational zone on initial hs-cTn and who require serial hs-cTn, will be identified for potential recruitment. The times for recruitment will be from 8am to 4pm, Mondays to Fridays (inclusive). If clinically, it is felt that there is a need for serial hs-cTn, the patients will be randomized to undergo either (Arm A): early CTCA along with a serial second hs-cTnT; or (Arm B): undergo standard of care involving serial hs-cTnT alone. Patients in both arms will be consented to have CTCA. However, Arm B (standard of care arm) will be blinded from CTCA findings and will have standard of care based clinical management according to serial hs-cTn. The CTCA data in Arm B will be used for Study 2 (see below).
Arm A: CTCA assessment will be carried out in Arm A while the patient would normally be waiting to have their repeat serial hs-cTn taken or waiting for the blood test result. The CTCA image interpretation followed by reporting will be carried out as early as possible in the acute hospital setting, while the patient is an in-patient. The CTCA will be interpreted and reported by an experienced Radiologist or Cardiologist with a minimum of Level II certification in cardiac CT angiography. Angiograms will be reported using the standard 15 segment model [33]. A stenosis will be graded in severity according to the following classification, as described in the Society of Cardiovascular Computed Tomography (SCCT) Guidelines [34]:

(a) Normal: 0%
(b) Minimal: 1-24%
(c) Mild: 25-49%
(d) Moderate: 50-69%
(e) Severe: 70-99%
(f) Total Occlusion: 100%

Patients with <25% stenosis will have AMI ruled-out. The reason for selection of this cut off (<25%) has been discussed previously but, to summarize, multiple studies have shown that <50% stenosis on CTCA corresponds with a favorable prognosis compared with >50% stenosis and also <50% stenosis has been shown to not be associated with AMI at 30 days’ follow-up. Therefore, we have selected a more conservative value of <25% stenosis on CTCA to rule out AMI [19-22]. Patients with <25% stenosis may be considered for discharge or alternative reasons for their troponin rise may be investigated by the hospital care team e.g. renal failure, myocarditis, pulmonary embolism etc.

The results of these CTCA scans will be made available to the patients’ clinical care team and further management decisions will be left to their discretion.

Arm B: Patients in this arm will be managed according to standard of care, which includes serial hs-cTn testing. As stated, these patients will also have CTCA carried out, but the CTCA assessment will not form part of the patients’ clinical management as this arm will be blinded to CTCA findings. Furthermore, unlike Arm A, CTCA image interpretation will not take place in the acute hospital setting. It will be carried out...
out in the following days, again by an experienced Radiologist or Cardiologist with a minimum of Level II certification in CTCA. The whole CTCA procedure will be carried out after the patient has had their hs-cTn taken and while the patient is waiting for their hs-cTn result (as we would not like the CTCA to delay the staff members from taking the blood test). Should the CTCA on a patient in Arm B, be found to have significant high risk CAD e.g. >50% stenosis in the left main (LM) coronary artery, and/or >50% stenosis in the proximal left anterior descending (LAD) coronary artery, they will be un-blinded, taken out of the study and kept in a separate registry. Data collected up to that point will be kept by the research team. Their results will be discussed with the hospital care team and if they have not had any invasive coronary imaging during the preceding hospital admission, an urgent cardiology out-patient referral will be made to enable further clinical management.

**Standard of Care Acute Chest Pain Management Algorithm at Guy’s and St. Thomas’ (Arm B)**
Study 1

Suspected ACS

ECG Normal

Troponin

Low Risk
Trop < 5ng/L
Discharged

Intermediate Group
Trop: 5-51ng/L

High Risk
Trop: >52ng/L
Admitted & referred to cardiology

Consent

Randomize

(Arm A)

CTCA

CTCA + Standard of care

Stenosis <25%

Exploit alternative diagnoses/Discharge

CTCA Results made available to hospital care clinical teams. Further clinical management to be decided by the hospital care clinical teams.

Stenosis ≥ 25%

(Arm B)

CTCA

* Standard of Care
Serial Trop etc (Blind to CTCA)

Management plan as per Standard of Care

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**Study 2: Sub-analysis of CTCA + biomarkers arm (Arm B):** The study also contains an observational arm to evaluate the influence of advanced CTCA diagnostic information on clinical risk categories and clinical decisions, incremental to the original risk category and clinical management plan based on hs-cTn alone. Retrospective analysis of the CTCA data-sets will be carried out (at a later date) including, FFR-CT (see below) and plaque characterization (see below). Thereafter this information will be revealed to a select group of clinicians, who will be asked (in a virtual setting) to comment on possible changes to their original (hs-cTn based) clinical management plans in the light of the retrospective information gleaned from the existing CTCA datasets. From existing CTCA luminal stenosis data, the cardiology clinicians will be asked to comment on any changes to their clinical management plan if they were given the following information:

(i) hs-cTn + CTCA stenosis  
(ii) CTCA stenosis + FFR-CT  
(iii) CTCA stenosis + CT plaque characterisation  
(iv) A combination of the above

We will also make a comparison between these virtual plans of action and actual course of action among patients who undergo invasive coronary angiogram +/- invasive FFR assessment as part of their routine care.

The rationale behind the use of FFR-CT has been discussed previously (Section 1.3). The CTCA DICOM data-sets will first be anonymized and subsequently couriered to Heartflow (Redwood City, California, USA) on an encrypted external hard drive for full post hoc processing to derive FFR-CT values. A research collaboration will need to be agreed between Guy’s and St. Thomas’ Hospital, King’s College London and Heartflow in this regard. From preliminary data, we believe that out of 250 recruited patients, for Study 1, we would potentially require FFR-CT analyses on approximately 85 cardiac CT cases in total (who would have at least $\geq 25\%$ stenosis). The FFR-CT analysis will be carried out on retrospectively on patients already recruited to the trial and prospectively on patients that have yet to be recruited.

The rationale behind CTCA plaque characterization will be discussed below.
CT-Plaque Characterization

AMI results from sudden coronary luminal thrombosis, which can occur from any of three underlying pathological lesions: plaque rupture, plaque erosion and calcified nodules. Plaque rupture represents the majority of the underlying pathologies for AMI and the precursor coronary lesion is known as thin capped fibroatheroma (TCFA). These tend to be composed of a large lipid-rich necrotic core, thin and intact fibrous cap, spotty calcium, inflammation due to infiltration by macrophages and some smooth muscle cells [35].

Imaging with modern cardiac CT scanners enables the identification of coronary lesions with features of TCFA which could be prone to rupture and hence AMI. The high risk morphological features of TCFA on CTCA plaque assessment include: (a) napkin ring sign (b) positive remodeling (c) spotty calcification and (d) low attenuation.

(a) Napkin Ring Sign: A term used to describe the CTCA appearance of non-calcified plaque with a central area of low CT attenuation and an outer ring-like higher attenuation plaque. It has been shown to have a high specificity in identifying TCFA (94.1%) [36], and also to be strongly associated with future ACS events, independent of other high-risk coronary CTCA features like positive remodelling, and low attenuation [37].

(b) Positive Remodelling: This describes the preservation of the vessel luminal area despite the presence of compensatory enlargement of the vessel wall due to atherosclerosis. Lesions with positive remodelling on CTCA compared to lesions without positive remodelling, have been shown to possess a significantly larger percentage of necrotic core and a higher prevalence of TCFA when assessed with virtual histology intra-vascular ultrasound (IVUS) [38]. In a study by Motoyama et al, the authors found positive remodelling was found to be significantly more frequent in patients with ACS compared to those with stable angina (87% vs12% p < 0.0001) [39].
(c) **Spotty Calcification:** Coronary artery calcification always indicates underlying coronary atherosclerosis and has been shown to be associated with poor clinical outcomes even in asymptomatic patients [40, 41]. Spotty calcification is the presence of small dense calcified plaque (>130HU) deposit(s) surrounded by non-calcified plaque and these can be classified according to size into small (<1mm), intermediate (1-3mm) and large (>3mm). On IVUS examination, the finding of small spotty calcification has been found to be significantly more frequent among coronary lesions with high percentage necrotic core and plaques. Furthermore, lesions with small spotty calcification were also shown to have the highest percentage of TCFA compared with large spotty or dense calcifications [42]. In multiple studies the presence of spotty calcification has been shown to be associated with ACS as compared with lesions found in stable angina [39, 43, 44].

(d) **Low attenuation:** On CTCA, low attenuation has been seen to be a consistent feature of lipid-rich plaque. In a multimodality imaging study by Ozaki et al, the authors found that among culprit lesions causing acute coronary syndrome (ACS), 71% had ruptured fibrous caps and the remainder had intact fibrous caps, whereas all patients with stable angina had intact fibrous caps, when imaged by optical coherence tomography (OCT) coronary imaging. CTCA imaging of these patients revealed that low-attenuation plaques (defined as <30 HU) were significantly more frequent (88%) among patients with ruptured fibrous caps/ACS compared with intact fibrous caps/stable angina (18%). They also found that positive remodelling and spotty calcification were significantly more frequent among patients with ruptured fibrous caps than stable lesions. However, these features (low attenuation, positive remodelling or spotty calcification on CTCA) were unable to differentiate between stable lesions and intact fibrous cap lesions associated with ACS [43].
Study 2. Sub-analysis of CTCA + biomarkers arm (Arm B):
Study 2: Sub-analysis of CTCA + biomarkers arm in more detail (Arm B):

1. How would the addition of CTCA luminal stenosis reclassify (upgrade or downgrade) patients into low, intermediate and high risk groups compared with biomarkers risk category?
   a. How would this information change management?
   b. Clinical outcomes of patients in each risk category (rates of death, MI, unstable angina, hospital readmissions, coronary revascularisation)
   c. Which findings on CT were associated with clinical outcomes?

2. How would the addition of plaque characteristics to luminal stenosis reclassify patients into low, intermediate and high risk groups compared with biomarkers risk category?
   a. How would this information change management?
   b. Clinical outcomes of patients in each risk category (rates of death, MI, unstable angina, cardiac related hospital readmissions, coronary revascularisation)
   c. Which findings on CT were associated with clinical outcomes?

3. How would the addition of FFR-CT to luminal stenosis reclassify patients into low, intermediate and high risk groups compared with biomarkers risk category?
   a. How would this information change management?
   b. Clinical outcomes of patients in each risk category (rates of death, MI, unstable angina, cardiac related hospital readmissions, coronary revascularisation)
   c. Which findings on CT were associated with clinical outcomes?

4. How would the combination of these factors affect influence risk category/management?

5. Correlation of serial high-sensitivity cardiac troponin levels and diagnoses of MI/unstable angina with CTCA e.g. across various degrees of stenosis (<25%; 25%-49%; 50%-69%; >70%), high risk plaque features and FFR-CT?

2.4 Primary Endpoint (Study 1)

The primary objective will be to compare median hospital length of stay in each arm.

2.5 Secondary Endpoints (Study 1)

- Number of admissions in each arm;
- Number of discharges in each arm;
- Time taken to arrive at decision for admission or discharge;
- Number of additional investigations during hospital stay (if admitted);

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• Proportion of patients with completeness of diagnosis on discharge;
• Rates of OPD referrals at discharge;
• Rates of OP cardiac testing referrals at discharge
  - Rates of ICA referrals in each arm
  - Rates of negative ICA
• Number of cardiac out-patient clinic visits during 1 year;
• Time taken for completeness of diagnosis in each arm;
• Number of cardiac related AE revisits in each arm over 1 year;
• Number of cardiac related hospital re-admissions in each arm over 1 year.

**Patient Experience**
Patient Satisfaction/QoL at baseline, 1, 2, 3, 6, 9, and 12 months.

**Safety**
Differences in terms of radiation dose in each arm.

**Health Economics**
Cost of ED visit.
Total healthcare cost in each arm at 6 months and 1 year.
Total hospital admission costs in each arm.

**Clinical Endpoints:** Rates of death, ACS, revascularization at 30 days, 6 months, 12 months.

### 2.6 Study Statistics
We will first inspect the normality of the distribution of the outcome variable. If it appears as though the distribution is not normal as expected, then we will use non-parametric tests (Mann-Whitney U test); differences between groups will be constructed using 10,000 bootstrap simulations on the difference in medians, and derive associated confidence intervals and p-values. If there are any significant imbalances in any covariate(s) between the two groups, then we will also perform quantile (specifically median) regression analysis on the difference between median length of stay between the two groups, adjusted for these covariate(s). To estimate the standard errors for the difference in medians, 10,000 bootstrap simulations of this quantile regression will be performed. If there are any significant imbalances, then the adjusted analysis will be considered the main analysis, otherwise the univariate analysis will be taken to be the main analysis. If the data are Normally distributed then standard regression techniques will be used.
2.7 Cost and Economic Analysis

The cost and cost-effectiveness analyses will assess whether the addition of CTCA within the Emergency Department setting to the conventional clinical pathway without acute imaging will produce any changes in terms of total costs and/or cost-effectiveness analyses. For the purposes of the secondary objectives of cost analyses and economic evaluations (consistent with secondary outcomes) quality of life and symptoms will be measured using the EQ-5D-5L questionnaire at baseline after the ED episode and then monthly for the first three months and three monthly thereafter. All relevant costs from an NHS and Personal Services perspective will be considered using a top-down costing strategy (consistent with GSTFT finance data). Cost-effectiveness will be estimated in terms of the incremental cost per quality-adjusted life year (QALY) of comparing both clinical pathways (with and without the use of CTCA in acute setting). This ratio will be calculated using the area under the curve for health utility using the EQ-5D-5L and health service costs up to one year. Sensitivity analyses will explore the potential impact of major adverse events upon lifetime costs and QALYs as well as the adoption of a societal perspective. Existing published models will constitute the base for long-term modelling of both clinical pathways. Lifetime QALYs and costs of surviving patients will be estimated from published sources of life expectancy, annual costs and corresponding annual utilities. It is hypothesised that patients in whom coronary artery disease is identified, will adhere better to strategies that include primary and secondary prevention. This means that the early use of CTCA might hold benefits in the short-term) as well in the medium and long-term.

2.8 Timeline

In our internal audit, patients who presented with acute chest pain to the ED at GSTFT, and were found to be in an intermediate grey zone on initial troponin analysis and who required a second troponin amounted to 26 patients per week (Monday to Sunday), which works out to be over 3 patients per day. As we are going to recruit patients Monday to Friday from 8am to 4 pm, it is anticipated that we may able to
recruit 4-5 patients per week in total. Given the target of 250 patients in the study, recruitment is likely to take approximately 12-15 months to achieve.

**Follow up Procedures**

Patients will be followed up at 1, 2, 6, 9 and 12 months following the hospital visit, in order to capture all relevant costs and outcomes.

In the event of patient death or failure to comply with study requirements, he/she will be excluded from the study. It is estimated that 30% of participants enrolled in the study may be lost to follow-up.

**Data collection**

**General and study specific data**

Data will be collected by the research team from routinely collected NHS records and will include several categories, such as: baseline demographics, co-morbidities, ECG results, admission and discharge diagnoses, cardiology and other relevant investigations or interventions, repeat hospitalizations and adverse events. Study specific data will also be collected such as: radiation dose per CTCA scan, timing of interventions, report of incidental findings and any adverse events.

**Patient diaries and questionnaires**

Patients will receive a call (at 1, 2, 3, 6, 9 and 12 months) to collect key information around resource use, patient quality of life and patient satisfaction. All patients will be provided with a diary in the registration pack after the initial episode at the ED. In these patient diaries, patients should record all hospital and GP visits, community care, medications and investigations. Quality of life will be assessed using a standard questionnaire (EQ-5D-5L questionnaire). Patient satisfaction will be evaluated using a 0-10 scale.

**3. CTCA Procedures and findings**

3.1 CTCA Procedure

The CTCA exam will be performed on a new generation CT scanner, i.e. a multi-detector dual-source CT scanner. This CT scanner will be used for both clinical and research purposes. Given the need for possible 1 scan per day, we do not anticipate logistic difficulties in completing the CT scans. Only GSTFT standardized REC reference number: 17/EM/0375; IRAS Project ID: 223704

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prospective ECG-gated protocols will be used to perform the CTCA exam. This will significantly reduce the overall radiation dose to below 9 mSv per CTCA scan. This dose assessment is based on the dose for a typical patient as there will be normal variation around the average dose due to individual subjects’ body habitus and heart rate. If, for some reason, the use of prospective ECG-gated protocols is not possible, the CTCA scan will not be carried out, and therefore the patient will not enter the study. Female patients of potential child bearing age will be screened for the possibility of pregnancy according to the local Guy’s and St. Thomas’ Radiology protocols.

We will try to ensure optimum CTCA images by attempting to minimize coronary and chest wall motion artefact through reducing heart rate to below 63 beats per minute (bpm) and by getting the patients to practice breath holding for 10 – 12 seconds. If the heart rate is above 63 bpm and the systolic blood pressure (BP) is above 100 mmHg, intravenous beta-blockers (e.g. metoprolol 5-30mg) will be given to achieve the target heart rate. In order to further optimize coronary images, sublingual glyceryl trinitrate (GTN) will be given if the systolic BP is above 90 mmHg. A small dose of oral diazepam may also be given to improve heart rate control in patients who may be anxious. Pre-CTCA renal function will be available from routine bloods samples that are taken as part of standard of care work-up of patients presenting to the ED with acute chest pain of suspected cardiac origin. As stated previously, CTCA assessment will be carried out in Arm A while the patient would normally be waiting to have their repeat serial hs-cTn taken or waiting for the blood test result. This is in contrast to Arm B, where the CTCA procedure will be carried out after the patient has had their hs-cTn taken and while the patient is waiting for their hs-cTn result (as we would not like the CTCA to delay the staff members from taking the blood test).

### 3.2 CTCA Image Interpretation and Reporting

The CTCA will be interpreted and reported by an experienced Radiologist or Cardiologist with a minimum of Level II certification in cardiac CT angiography. Angiograms will be reported using the standard 15 segment model [33]. A stenosis will be graded in severity according to the following classification:

(a) Minimal: 0-24%

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(b) Mild: 25-49%
(c) Moderate: 50-70%
(d) Severe: >70%
(e) Total Occlusion: 100%

Patients with <25% stenosis will have AMI ruled-out. The reason for selection of this cut off (<25%) has been discussed previously but briefly the reasons are that multiple studies have shown that <50% stenosis on CTCA corresponds with favorable prognosis compared with >50% stenosis and also <50% stenosis has been shown to not be associated with AMI at 30 days’ follow-up. Therefore, we have selected a more conservative value of <25% stenosis on CTCA to rule out AMI [19-22].

3.3 CTCA Results

For Arm A, CTCA image interpretation followed by reporting will be carried out as early as possible in the acute hospital setting, while the patient is an in-patient. The results will be made available to the patients’ clinical care team and further management decisions will be left to their discretion.

As stated previously, patients in Arm B will also have CTCA carried out but the CTCA assessment will not form part of the patients’ clinical management as this arm will be blinded to CTCA findings. Furthermore, unlike Arm A, CTCA interpretation followed by reporting will not necessarily take place in the acute hospital setting and therefore will be carried out in the following three weeks. Should the CTCA be found to have significant high risk CAD e.g. >50% stenosis in the left main (LM) coronary artery, and/or >50% stenosis in the proximal left anterior descending (LAD) coronary artery, they will be un-blinded and kept in a separate registry. Their results will be discussed with the hospital care team and if they have not had any invasive coronary imaging during the preceding hospital admission, an urgent cardiology out-patient referral will be made to enable further clinical management.

3.4 CTCA Incidental Findings

Pooled studies show: (i) an incidental extra-cardiac finding in 44% of patients undergoing CTCA; and (ii) the diagnosis of a major finding in 16% of the CTCA exams [45]. Incidental findings on CTCA will be documented in the CTCA report. In the case of Arm A (Study 1), the clinical care team will be made aware of the finding.
through the report. In Arm B (where the CTCA images will be evaluated at a later date), any clinically significant findings e.g. cancers and/or prognostically significant coronary artery disease will be notified as a Radiology alert to the clinical care team and the patient’s general practitioner.

4. **Sample Size, Selection and Withdrawal of Subjects**

4.1 Sample Size

Waiting times often exhibit a skewed distribution, and so the sample size calculation was based on the difference in median waiting time.

To estimate the sample size needed to observe a one-hour reduction in median hospital length of stay, normal techniques based on standard deviation estimates are not valid. We therefore used a random sample of 49 patients undergoing the current pathway as the control ‘population’, and created an equivalent treatment ‘population’ by multiplying the waiting times of the 49 sampled patients by a constant such that the median was reduced by one hour; this constant was found to be 0.799.

For a given sample size \( n \), 10,000 Monte Carlo simulations were performed by sampling \( n \) patients with replacement from each of the two groups, and the p-value from a Mann-Whitney U test was calculated for each simulation. The proportion of these 10,000 simulations with a p-value below 0.05 was recorded as the power for that sample size \( n \). The sample size was varied until a power of 0.8 was obtained, and was found to be **250** patients in total (**125** patients in each arm of the study).

Patient drop-out is anticipated to be minimal as all patients, by definition of the primary outcome, will be in hospital for the length of their hospital stay, and therefore their length of stay will be recorded.

4.2 Inclusion Criteria

1. Patients above 18 years of age with ischaemic sounding chest pain prompting visit to the emergency department (suspected ACS).
2. No-ischaemic ECG changes (i.e. no ST-segment elevation or depression ≥ 1mm in 2 or more contiguous leads, and/or T-wave inversions).

3. Episode of chest pain within last 12 hours.

4. Initial troponin in the intermediate range (5-50ng/L).

4.3 Exclusion Criteria

1. STEMI.

2. Initial troponin < 5ng/L or >50ng/L.

3. Signs and symptoms of acute heart failure and/or haemodynamic instability.

4. Dynamic ischaemic ECG changes.

5. Patient not suitable to undergo CTCA
   a. Inability to breath hold for 10 seconds
   b. Severe renal impairment (eGFR <30 mL/min)
   c. Contraindication to beta-blockers

6. Atrial Fibrillation on ECG.

7. Patients with known significant obstructive coronary artery disease (>50% stenosis) on previous invasive or CT coronary angiogram.

8. Patients with previous PCI/CABG revascularisation.

9. Patients with a history of congenital heart disease.


11. Patients who lack capacity to give consent or participate in the study.

12. Previous recruitment to the present study.

13. Known pregnancy or patients who are currently breast feeding.


15. Patients involved in current or a recent (within the last 4 months) CTIMP trial.

4.4 Criteria for Premature Stopping of the Trial

If 5 consecutive participants are randomised to Arm A of the study (Cardiac CT + standard of care), and cardiac CT is not available within the required time-frame.
5. **Study Procedures**

5.1 **Screening Procedures**

Patients with suspected ACS eligible for the study will enter GSTFT via the ED at St Thomas’ Hospital. As part of their standard care, all patients will be clinically assessed on arrival by the routine clinical care team. Subsequently, if the initial ECG shows no ischemic changes and the initial hs-cTn result cannot rule in or rule out ACS, and there is a need for a serial hs-cTn test, the patient will be identified as a potential recruit to the study. Subsequently if the patient meets at least one of the inclusion criteria (and none of the exclusion criteria), a trained member of staff will be responsible for taking written signed informed consent from the patient.

A screening log must be maintained by the site and kept in the Investigator Site File. This must record all potentially eligible patients approached about the study and the reasons why they were not registered in the study if this is the case.

5.2 **Consenting Participants**

Once a potential participant is identified by the routine care team, the patient will be approached by research staff, to discuss the study with the patient. The Investigator, or a person appropriately trained and delegated by the Investigator (as documented in the site delegation log) is responsible for obtaining and documenting informed consent (either verbal or written as abovementioned) from each subject prior to any participation/study specific procedures. This procedure will be supported by a patient information sheet that appropriately explains the aims, methods, anticipated benefits and potential hazards of the study.

Following agreement between Heartflow and GSTFT/KCL, for purposes of FFR-CT analysis, patients who have already been recruited in Study 1 will be consented retrospectively for the FFR-CT analysis by being contacted via a phone call. Following agreement, all future patients (if any have yet to be recruited) will be consented for potential FFR-CT in the hospital setting.

It is anticipated that the consent process will take no longer than 15 minutes.

If the patient shows no interest in taking part in the study, he/she will not be included in the study. If the patient shows interest in taking part in the study, the patient information sheet will be given to the patient and discussed with him/her. Potential
risks and benefits should be discussed with the patient (and their accompanying
relative/companion, if present and appropriate). It will be explained to the patient that
it is his/her right to ask to be withdrawn from the study at any point in time.

During these discussions, the current approved patient information sheet for the study
will be discussed with the patient (and, if present and appropriate, their accompanying
relative). The recruitment process and initial tasks to be performed, both for the
Pathway 1 and Pathway 2 clinical pathways, are illustrated in the flowchart below in
Figure 4 and Figure 5, respectively.

**Summary of Consent Process**

- Patient presenting with ACP assessed at A&E
- Initial investigations including ECG and troponin place patient in the intermediate observational category.
- Doctors deem a serial troponin test to be necessary.
- Patient signs consent
- Patient registered on study
- Patient randomized to Arm A or Arm B of study

Potentially eligible participants who are willing to take part in the study will be asked
to provide informed consent. Written informed consent on the current approved
version of the consent form for the study will be obtained before any study-specific
procedures are conducted, and a copy will be given to the patient and kept in the
patient’s medical notes. The discussion and consent process must be documented in
the patient notes and will be obtained by a trained member of the clinical team or a
member of the research team.

The patient’s capacity will be assessed by trained and delegated clinical/research staff
who have completed study specific training and have been delegated this
responsibility by the Principal Investigator (PI).

GSTFT staff are responsible for:

- Assessing the patient’s capacity to provide informed consent.
- Checking that the current approved version of the information sheet and
  consent form are used.
- Checking that information on the consent form is complete and legible and the patient has completed/initialled all relevant sections and signed and dated the form.

- Checking that an appropriate member of staff has countersigned and dated the consent form to confirm that they provided information to the patient.

- Checking that an appropriate member of staff has made dated entries in the patient’s medical notes relating to the informed consent process (i.e. information given, consent signed etc.).

- Following registration:
  - Adding the patient study number to all copies of the consent form, which should be filed in the patient’s medical notes and investigator site file.
  - Giving the patient a copy of their signed consent form and patient information sheet.

- Respecting the right of the patient to refuse to participate in the study without giving reason as all patients are free to withdraw at any time.

5.3 Randomization Procedures

Once patients consent to participate in the study, they will be randomized into the intervention group (i.e. with CTCA) or the control group (i.e. hs-cTn based standard of care) on a 1:1 ratio. For purposes of Study 2, the control group of patients will also be consented to undergo CTCA. However, CTCA will not form part of their in-patient clinical management as the clinical teams will be blinded from CTCA findings (except for cases of prognostically significant coronary disease e.g. 50% stenosis of the LM and/or proximal LAD coronary arteries).

Randomization will be carried out via the use of opaque sealed envelope block randomization method. Both the block randomization list and the sealed envelopes will be produced by the statistician. Each block will contain 5 envelopes, which would translate to 50 blocks. 25 blocks will contain 3 envelopes for Arm A and 2 envelopes for Arm B. The remaining 25 blocks will contain 3 envelopes for Arm B.
and 2 envelopes for Arm A. Each block will also be randomly arranged. The sealed opaque envelopes/blocks used to assign patients to either arm will be prepared by an individual external to the study. The recruiter will not be able to identify which arm a potential participant is going to be randomized to until after he/she has received informed signed consent from the potential participant.

Once randomized onto the study, the patient will be given a study number. This will be documented in the enrolment log.

5.4 Radiology Assessments

Radiological assessments will be used in the both arms of Study 1. However, the clinical pathway as outlined in Study 1 is likely to increase the radiation burden as CTCA is an imaging modality which uses ionizing radiation. In order to decrease the overall radiation burden, and the risks associated, several processes are going to be respected:

- The clinical pathway outlined in Study 1 will only consider the use of prospective CTCA scanning protocols on a new generation CT scanner. This will lead to low radiation doses (below 9 mSv) while maintaining the image quality and high diagnostic performance.

- If, for some reason, (e.g. patients with elevated heart rate despite the use of oral and/or intravenous beta-blockers) it is not possible to use prospective CTCA scanning protocols, the patient will not undergo the CTCA examination and therefore will not enter the study.

Given the potentially life threatening condition under review, it is considered that the potential benefits of using CTCA outweigh the potential risks.

5.5 End of Study Definition
For regulatory purposes the end of the study will be 12 months after recruitment of the final patient at which point the ‘declaration of end of study’ form will be submitted to ethical committees, as required.

6. **Assessment of Safety**

A serious adverse event is any untoward medical occurrence that:

- Results in death;
- Is life-threatening*;
- Requires in-patient hospitalization or prolongation of existing hospitalization;
- Results in persistent or significant disability/incapacity; or
- Other important medical events**.

**Notes:**

*The term "life-threatening" in the definition of "serious" refers to an event in which the participant was at risk of death at the time of the event; it does not refer to an event which hypothetically might have caused death if it were more severe.

**Other events may be considered a serious adverse event when, based upon appropriate medical judgement, the event may jeopardize the participant and may require medical or surgical intervention to prevent one of the outcomes listed above.

6.1 **Ethics reporting**

A serious adverse event (SAE) occurring to participant would be reported to the REC that gave a favorable opinion of the study where in the opinion of the Chief Investigator the event was: ‘related’ – that is, it resulted from administration of any of the research procedures; and ‘unexpected’ – that is, the type of event is not listed in the protocol as an expected occurrence. Reports of related and unexpected SAEs would be submitted within 15 days of the Chief Investigator becoming aware of the event, using the NRES report of serious adverse event form.

All related AEs that result in a patient’s withdrawal from the study or are present at the end of the study, should be followed up until a satisfactory resolution occurs. It will be left to the investigator’s clinical judgment whether or not an AE is of sufficient severity to require the patient’s removal from treatment. A patient may also voluntarily withdraw from treatment due to what he, or she, perceives as an
intolerable AE. If either of these occurs, the patient would undergo an end of study assessment and be given appropriate care under medical supervision until symptoms cease or the condition becomes stable.

7. **Study Steering Committee**

The Study Steering Group will be chaired by [ Placeholder ] who is acting as an external advisor to this study. The Study Steering Group will meet at fixed points during the study and will include patient representatives.

All GSTT clinical governance protocols will be respected during the conduction of the present trial.

Data Monitoring and Ethics Committee (DMEC) functions will be embedded in the Study Steering Committee. The Study Steering Committee will have access to unblinded comparative data. The committee will monitor data collection methods and make recommendations regarding whether there are any ethical or safety reasons why the study should not continue.

8. **Ethics & Regulatory Approvals**

East Midlands Leicester South Research Ethics Committee

9. **Data Handling**

9.1 Confidentiality

The study staff will ensure that the participants’ anonymity is maintained. The participants will be identified only by a participant identification (ID) number. This ID number will be coded in such a way that participants cannot be identified. All documents will be stored securely and only accessible by study staff and authorised personnel.

Different sources of data will be collected by trained staff at different points in time (as illustrated in Figure 3 and Table 1). If an external organisation is to capture data on behalf of the study team such as follow-up data through automated systems (i.e. automated text message systems) this needs to be previously agreed with the GSTFT governance team and a formal agreement will be be established under GSTFT terms of data protection policies.
As previously mentioned, the participant identification (ID) number will be provided as soon as feasible, during the initial procedure of registration in the study immediately following the informed consent signature.

No patient identifiable data will be transferred outside the EU.

9.2 Case Report Form

Trained staff (as per the delegation log) will be responsible for the completion of the CRF.

9.3 Record Retention and Archiving

At the end of the study, GSTFT will archive securely all centrally held study related documentation for a minimum of 5 years. Arrangements for confidential destruction will then be made. It is the responsibility of PIs to ensure data and all essential documents relating to the study held at site are retained for a minimum of 5 years after the end of the study, in accordance with national legislation and for the maximum period of time permitted by GSTFT.

9.4 Compliance

The study will comply with the Data Protection Act which requires data to be anonymised as soon as it is practical to do so and no non-anonymised data will be used for the purposes of the study or subsequent study publication.

9.5 Clinical Governance Issues

All GSTFT clinical governance protocols will be respected during the conduction of the present study.

9.6 Non-Compliance

GSTFT may require a report on the incident(s). If GSTFT staff are unsure whether a certain occurrence constitutes a deviation from the protocol, the GSTFT study team can be contacted immediately to discuss (via email - ACPint-toheti@kcl.ac.uk – or phone on 0207 188 9529).

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GSTFT will use an organisation’s history of non-compliance to make decisions on future collaborations.

10. Finance and Publication Policy

The study is fully funded by a grant secured from Guy’s and St Thomas’ Charity. The contact details are listed below:

- Name and address of funder:
  - Name: Guy’s and St Thomas’ Charity
  - Address:
    Guy’s and St Thomas’ Charity
    Second Floor, Francis House
    9 King’s Head Yard
    London
    SE1 1NA

- Telephone: 020 7089 4550
- Fax: 020 7089 4585
- Email: grants@gsttcharity.org.uk

Authorship Policy

All data collected as part of the study will reside with the research team. Once the study is completed, all study data will be analysed and documented. The authors of this document are listed in the first pages of this protocol.
**Publication**

The present study is aimed at publishing and presenting data to peer reviewed journals and scientific meetings. If successfully completed, it is anticipated the main paper from this project will be published in leading medical journals.
References

14. Budoff, M.J., et al., Diagnostic performance of 64-multidetector row coronary computed tomographic angiography for evaluation of coronary artery stenosis in individuals without known coronary artery disease: results from the prospective multicenter ACCURACY (Assessment by


28. Norgaard, B.L., et al., Diagnostic performance of noninvasive fractional flow reserve derived from coronary computed tomography angiography in suspected coronary artery disease: the NXT trial (Analysis of Coronary


42. van Velzen, J.E., et al., Comprehensive assessment of spotty calcifications on computed tomography angiography: comparison to plaque characteristics.
