1. A full lipid profile is measured at first presentation
2. Patient education on lifestyle modifications for secondary prevention of cardiovascular disease are delivered
3. Patients are started on a high-intensity statin (Atorvastatin 80 mg) before discharge
4. Repeat lipid profile & liver function tests are obtained at their first outpatient clinic appointment
5. Ezetimibe should be considered in addition to high-intensity statin for patients who have not reached the lipid reduction target (>50% LDL-C reduction from baseline, or LDL-C < 1.4 mmol/L) or as an alternative lipid-lowering therapy in patients intolerant to statins

**Methods and Results**

After exclusion, a total of 203 inpatients at a district general hospital diagnosed with AMI from February 1st 2021 to September 31st 2021 were identified. Data was compiled from patient case records using clinical notes, a web-based laboratory reporting system, and healthcare summary records to assess relevant blood test results, ward round entries, and relevant correspondence including discharge and outpatient clinic letters. In the 8-month period, we have failed to achieve our >90% target threshold for any of the five criteria. 47% patients admitted with an AMI had lipid profiles taken on admission, and 72% had this retested at their follow-up outpatient review. 78% received lifestyle modification advice during admission, and high-intensity statin therapy was initiated for only 87%. For the 70 patients indicated for further lipid-lowering therapy with Ezetimibe, only 16% of them had received this recently licensed therapy.

**Abstract 170 Figure 1** A chart to show the percentage of patients which statified criteria 1-5 in our cholesterol audit

**Conclusion**

Dyslipidaemia is a leading reversible cause of cardiovascular morbidity and mortality, and opportunities to fully address this risk factor have not been consistently taken in secondary care. Ezetimibe has strong evidence on its efficacy in LDL reduction, hence strategies should be aimed at more effective identification of those who may benefit from this recently approved therapy. Cost-effective interventions such as educational presentations and poster information on relevant wards will be trialled with data collected to monitor the progress of each intervention as it is introduced.

**Conflict of Interest**

None

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**Introduction**

Hypercholesterolaemia is a major modifiable risk factor for acute coronary syndromes (ACS). In October 2021, the National Institute for Health and Care Excellence (NICE) recommended that the small interfering ribonucleic acid against proprotein convertase subtilisin/kexin type 9, inclisiran, be offered to certain patients, including those with a history of ACS and low-density lipoprotein cholesterol (LDL-C) level of ≥2.6 mmol/L despite maximum tolerated statin or other lipid-lowering therapy. We aimed to estimate the proportion of our recently treated ACS patients who are likely to have a NICE-defined indication for inclisiran. Method A systematically selected sample of records from patients treated for ACS at our centre from 2019–2021 were reviewed (n=370). Data on demographics, diagnoses, treatments and biochemistry results were collected. Proportion of patients with a NICE-defined indication for inclisiran was determined and 95% confidence interval calculated. Where required and valid, LDL-C was calculated using the Friedewald equation.

**Results**

Patients included had a median age of 67 (IQR 58–79) and 74.1% were male. The index diagnosis was ST-elevation myocardial infarction (STEMI) in 46.2% and non-STEMI/ACS in 53.8%. 97.3% were receiving a statin at time of follow-up, 4.1% ezetimibe and 0.3% a fibrate. Documented reasons for statin avoidance included previous adverse drug reactions and perceived futility in extreme frailty. Post-discharge measurement of lipid profile was performed in 319 (86.2%) of the cohort. Lack of measurement appeared influenced by changes related to the COVID-19 pandemic (20.3% after March 2020 vs. 7.0% before, odds ratio [OR] 3.4, 95% CI 1.7 to 6.7, p=0.0002). There was evidence of significant improvement in lipid profile between admission and first post-discharge measurement (e.g. total cholesterol 4.8 ± 1.4 vs 3.5 ± 1.1 mmol/L, p<0.0001). Of those patients with a post-discharge measurement, 29 (9.1%) had LDL-C ≥ 2.6 mmol/L. Of these, 24 were receiving maximum intensity statin therapy whilst 2 were receiving statin but not at maximum dose. 3 were statin intolerant and receiving ezetimibe but with the potential to add another non-statin lipid-lowering drug. At least 24 (7.5%, 95% CI 4.6 to 10.4) would therefore have a clear indication for inclisiran based on current NICE guidance. A diagnosis of STEMI was associated with increased likelihood of LDL-C ≥ 2.6 mmol/L (OR 2.6, 1.1 to 6.1, p=0.024). No other significant relationships with other characteristics were seen.

**Conclusions**

Based on these data, approximately 5 to 10% of patients with recent ACS treated in a typical UK centre can be expected to have an indication for inclisiran treatment. Having an accurate estimate in this population can help local resource planning and communication with primary care. We should ensure that monitoring of lipid profile after hospitalisation for ACS is not impacted long-term by the COVID-19 pandemic.

**Conflict of Interest**

None