

Abstract 204 Table 1 Baseline demographics of study population.

	ACS patients
n	92
Age in years (SD)	70.2 (12.4)
Male (%)	70 (76)
History of previous ACS, stroke or FLD (%)	35 (38)
LLT at baseline (%)	41 (44.5)
LDL-C of those not on LLT in mmol/L (SD)	2.89 (1.4)

Table 1. Baseline demographics of study population. ACS – acute coronary syndrome, FLD – fatty liver disease, LDL – low density lipoprotein, SD – standard deviation

A total of 33 patients (36%) were reviewed in the VRC. All of these patients underwent a 12-week blood test to assess response to therapy in contrast to 23.7% of patients discharged to primary care without VRC follow up. Clear guidance on goal-directed LLT including the ESC guideline-recommended target LDLc (<1.4 mmol/L) and alternative/additional strategies for lipid-lowering therapy (including referral to a lipid clinic, consideration of additional oral and parenteral agents) was provided in writing to primary care in all VRC patients, compared to 1.7% of the comparator group.

Conclusion Our data suggests that the VRC is an effective way of delivering European Society of Cardiology (ESC) guideline-directed recommendations on the management of dyslipidaemia in ACS patients.

This model also helps to streamline services and may be extended to other high risk groups including patients with stroke and those with unequivocally demonstrated ASCVD on computerised tomography coronary angiography (CTCA).

Conflict of Interest Nil

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A SINGLE CENTRE REVIEW OF THE RAPID ACCESS CHEST PAIN SERVICE, FOR PATIENTS WHO ARE SUBSEQUENTLY REFERRED FOR ANGIOGRAPHY +/- PROCEED. ARE WE DOING ENOUGH?

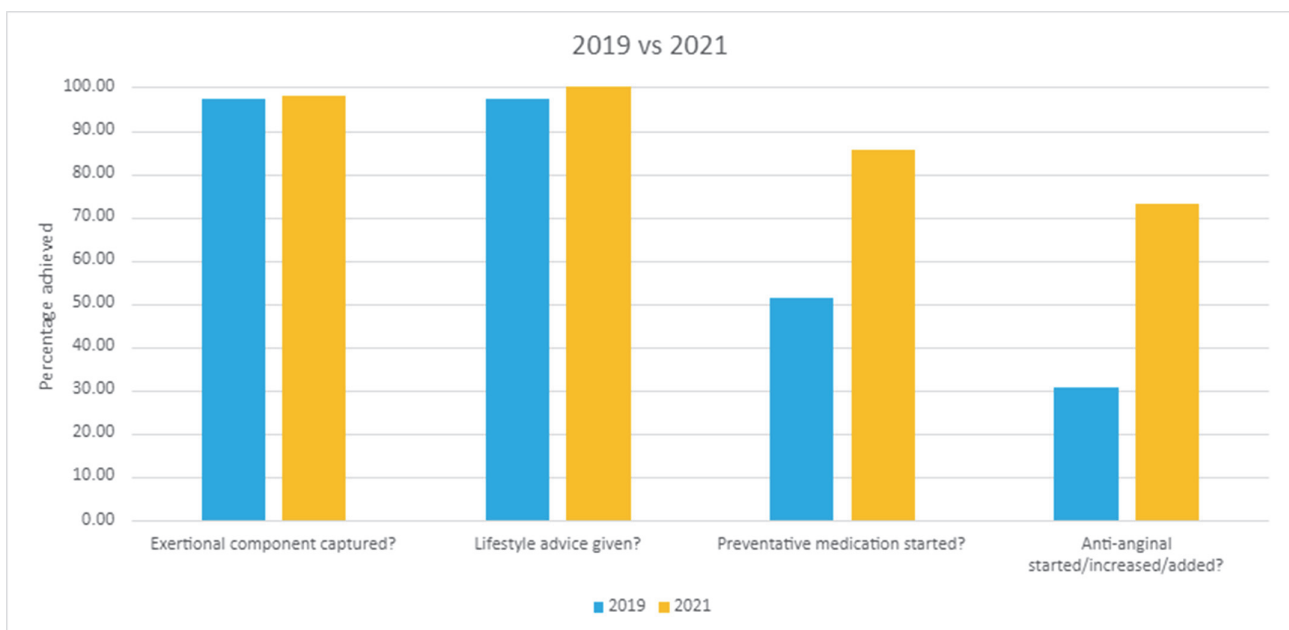
¹Thomas Key, ²Gareth Squire, ¹Simon Hetherington. ¹Kettering General Hospital; ²Glenfield General Hospital

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Introduction The 2019 European Society of Cardiology guidelines suggest that there is no role for angioplasty as a first line therapy for stable angina. Medical treatment, with both preventative and antianginal drugs, should form the basis of primary therapy. There has been a move away from invasive coronary angiography toward non-invasive testing for the majority of patients presenting with stable symptoms. Guidelines emphasise that clinicians should be ensuring that patients are on optimal medical therapy to both treat and prevent progression of stable coronary artery disease. Locally, the Rapid Access Chest Pain service (RACPC) offers a fast specialist nurse review, under consultant supervision, based on a departmentally accepted clinical proforma. From RACPC, either angina can be clinically excluded, or depending on risk profile referrals are made for both non-invasive and invasive investigations. Patients deemed to be at particularly high risk may be directly referred for coronary angiography with the option to proceed to PCI as required. Within this patient subgroup, it would be a reasonable expectation that these patients should be started on preventative medication, anti-anginal medication and counselled on risk factor modification.

Methods The local service was audited retrospectively over 3 months in both 2019 (pre covid) and 2021 (during covid). Basic demographic data, symptoms quality and angiogram result were captured. The criteria audited for compliance were as follows:

1. Whether patients were started on, or already on, preventative medication



Abstract 205 Figure 1

a. Defined as aspirin or statin.

2. Whether patients were started on an anti-anginal, or if already on an anti-anginal medication, had this medication up titrated or an additional medication added.

3. Had risk factor modification advice been offered.

Results During the first round of audit, 430 consecutive patients were reviewed to identify 78 cases referred for angiogram +/- proceed, male 45, female 33, average age 64. Of these patients felt to be high enough risk to warrant up front invasive assessment, it was found only 51% (n=40) of patients were started on preventative medication and only 31% (n=24) of patients had an anti-anginal medication optimised. Risk modification was offered in 97% (n=76). On clinical review symptoms were felt to be typical of CAD in 64% of cases (n=50), but on angiography obstructive disease was only demonstrated in 32% (n=25). After review of these data, a variety of changes were made in the RACPC service to improve the quality of this specialist review. Following these interventions, the service was re-audited. 258 consecutive cases were reviewed to identify 48 further patients referred for angiogram +/- proceed, male 24, female 24, average age 68, typical symptoms in 58% (n=28). There was a marked improvement in standards compliance (Figure 1), with 85% (n=41) of patients now being started on preventative medication and 73% (n=35) of patients having an anti-anginal optimised. Risk modification was offered in 100% (n=48). Obstructive disease was only demonstrated in 24% (n=11).

Conclusion It should be accepted that patients felt to be so high risk as to require invasive assessment with the associated procedural risks, should be on basic therapy as standard. This data suggests, that assuming that we as a specialist service are proficient in this, may not always be accurate. Following the first audit cycle, further training was delivered in the form of teaching sessions covering relevant pharmacology, guidelines and the stable CAD evidence base. The clinic proforma was adapted and justification was required if therapies were not started. Targeted intervention into clinical pathways can lead to positive improvement in standards and services.

Conflict of Interest Nil

206 LIPID LOWERING THERAPY IN PATIENTS WITH INCIDENTAL CORONARY ARTERY CALCIFICATION: A SINGLE-CENTRE OBSERVATIONAL STUDY

¹Rahul Chattopadhyay, ²Unni Krishnan, ²Max Brennan, ²Maria Wetscherek. ¹Cambridge University Hospital; ²Addenbrookes Hospital

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Introduction An incidental finding of coronary artery calcification (CAC) is a common finding on ungated CT thorax examinations. There is evidence that CAC correlates with formal Agatston calcium scores, and the risk of future atherosclerotic cardiovascular disease (ASCVD). National and international guidelines support the utilisation of CAC as a modifier during risk assessments.

Objectives We sought to ascertain the current state of CAC reporting on CT thorax, and lipid lowering therapy (LLT) in patients with identified CAC.

Methodology We conducted a single-centre retrospective observational study of patients undergoing a CT thorax for any indication. One hundred consecutive patients were examined. The electronic records of patients were used for data

Abstract 206 Table 1 Key study results

	Number of patients
n	100
Comment on CAC (%)	93 (93)
CAC present (%)	77 (83)
Mild (%)	43 (55.9)
Moderate (%)	21 (27.3)
Severe (%)	13 (16.9)
Recommendation for further management of CAC (%)	5 (6.5)
Baseline lipid profile performed (%)	21 (27.3)
LLT commenced or adjusted (%)	0 (0)
Communication with primary care (%)	0 (0)

Table 1 – Key study results

LLT (lipid lowering therapy), LDL-c (LDL cholesterol), ACS (Acute Coronary Syndrome)

collection on CAC reporting in the CT report, and for data on LLT management in those with CAC.

Results Of 100 consecutive patients undergoing CT thorax, 93 reported the presence or absence of CAC.

Of the 77 cases in which CAC was present, descriptive terms were variable and included terms such as “noted” without further description. For the purpose of this study, cases were grouped into mild, moderate and severe categories. Only 5 reports contained any specific recommendation regarding further risk assessment.

The referring clinician arranged lipid assessment in 16 of the 77 cases with CAC. Despite fifteen of these patients having sub-optimal LDL-c values, in no cases was LLT commenced or follow-up arranged. Moreover, in no cases was the presence of CAC or an adverse lipid profile communicated with the primary care team.

Table 1 outlines key results from the study.

Conclusion The incidental finding of CAC helps to identify patients who may benefit from lipid lowering therapy. Our study demonstrates that there are improvements that can be made in both the reporting and subsequent management of CAC. Recent reporting guidelines have emphasised the need for standardisation of reports and recommendations with respect to CAC. It is also of utmost importance that referring clinicians act upon CAC, and ensure patients are appropriately assessed and managed to reduce the risk of ASCVD.

Conflict of Interest Nil

207 DOAC NON-ADHERENCE FINDINGS FROM THE MY EXPERIENCE OF TAKING DOAC MEDICINES QUESTIONNAIRE (MYDOACMED)

¹Emmanouela Kampouraki, ²David Wardman, ²Lindsay McFarlane, ¹Rani Khatib. ¹Leeds Teaching Hospitals NHS Trust & Leeds Institute of Cardiovascular and Metabolic Medicine; ²Leeds Office of the West Yorkshire Integrated Care Board

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Background Non-adherence to Direct-acting Oral anticoagulants (DOACs) is around 25%. We designed and tested a modified version of the MYMEDS© tool (1), called The My Experience of Taking DOAC Medicines (myDOACmed)