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LIPID PROFILE AND LIPID LOWERING THERAPY PATTERNS AMONG PATIENTS WITH PRE-EXISTING CORONARY ARTERY DISEASE (CAD) RE-ADMITTED WITH MYOCARDIAL INFARCTIONS

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BACKGROUND: Individuals with documented CAD include those with previous myocardial infarctions (MI), previous coronary revascularization procedures (angioplasty or coronary artery bypass (CABG)) and those with significant plaques on angiography. This group is defined as being at "very high risk" of developing fatal or non-fatal cardiovascular events. The 2016 European Society of Cardiology and European Atherosclerosis Society Guidelines for the Management of Dyslipidaemias recommend an LDL target of below 1.8 mmol/L for this group. Guidelines also recommend using high intensity statins (atorvastatin or rosuvastatin) as secondary prevention after acute coronary syndromes.

OBJECTIVE: To determine lipid profiles and extent of lipid lowering therapies in individuals with pre-existing CAD admitted into UMMC with an MI.

METHODS: Retrospective, observational study of secondary prevention in patients with pre-existing CAD admitted with STEMI or NSTEMI in UMMC from September 2016 to January 2017.

RESULTS: 86 patients (62 males, 24 females) with a mean age of 64 years old were included. There were 20 (23%) STEMI and 66 (77%) NSTEMI cases. 20 (23%) patients had previous MI, 12 (14%) had previous CABG, 40 (47%) had previous angioplasty and 14 (16%) had non-revascularised CAD diagnosed on previous angiograms. The average LDL level was 2.61 mmol/L. 59 (69%) of patients did not meet target LDL levels of <1.8 mmol/L. 66 (77%) patients were on statin therapy, 1 (1%) on ezetimibe and 19 (22%) were not on any lipid lowering therapy. 41 (48%) were on atorvastatin, 20 (23%) were on simvastatin, 3 (3%) were on rosuvastatin and 1 (1%) was on fluvastatin. In the 20 patients with previous MI, 3 (15%) of them were not on high intensity statin (2 were on simvastatin, 1 patient was not on any lipid lowering therapy).

CONCLUSION: While recognizing that suboptimal lipid management in our small cohort may be explained by various factors including personal prescribing practices, side effects and patient compliance, our findings reflect other studies exploring suboptimal secondary prevention. Many studies have proven the benefit of aggressive lipid control on developing fatal or non-fatal cardiac events and efforts should be made to promote the practice of evidence based prescribing and target based medicine.