Frimley Health and Care ICS

November 2023

CARDIOLOGY

DXS Clinical Focus Flyer

Referral Forms

- FHFT – Advice and Guidance (A&G) Referral Form
- FHFT – General Cardiology Referral Form
  - ECG & FBC / U&E / LFT / TFT all patients
- FHFT – Rapid Access Suspected Angina Clinic (RASAC) Referral Form
  - Exclusions (refer general cardiology)
    - Known IDH or recent MI <12mths (refer Cardiology OPD)
    - Known or suspected significant valvular disease (refer Cardiology OPD)
    - Patients with significant comorbidities (refer Cardiology OPD)
    - Advanced cancer / advanced renal impairment
    - Reduced capacity
  - Do not refer
    - Normal invasive coronary angiogram within the last 5yrs
    - Men <30yrs, women <35yrs unless discussed with the team
  - 2 or more, refer RASAC
    - Constricting discomfort to the front of the chest, neck, shoulders, jaw, or arms
    - Precipitation by exertion
    - Relieved by rest or GTN in about 5 mins
  - **ECG, FBC / U&E / LFT / Chol / HbA1c all patients**
  - Start unless contraindicated in all referred patients
    - Aspirin 75mg
    - Bisoprolol 1.25mg
    - GTN spray
    - Consider statin therapy
- FHFT – Rapid Access Heart Failure Clinic (RAHFC) Referral Form
  - For new / suspected heart failure
  - Exclusion: Known heart failure with ECHO <12mths and / or known to Heart Failure team
  - Recent ECG, BNP / FBC / U&E / LFT / TFT, CXR, BMI
  - Start a loop diuretic and ACEI if no contraindications
- Referral for Suspected Familial Hypercholesterolaemia
  - Bloods needed: Fasting Chol (2x) & Gluc / U&E / FBC / TFT / LFT
- FHFT Community Heart Failure Nurse Specialist
  - Pts must have an ECHO, BNP & ECG
  - Reason for referral:
    - Newly diagnosed HF, exacerbations, titration of medication
    - Hospital avoidance, facilitate early discharge, palliative care
- Holter Analysis and Reporting Multiple Time Periods
  - Holter Duration: 24h / 48h / 72h / 7 days – please use the shortest appropriate duration
  - Presenting Symptoms
    - Palpitations / dyspnoea / fatigue / chest discomfort
    - Skipped beats, thumping beats, short flutterings
    - Palpitations with syncope / near syncope
    - Stroke / TIA / features of HF
  - Symptom History
    - Date of first episode & last episode
    - Frequency / duration / rhythm / onset / termination
  - Ppt Factors
    - Anxiety, stress, alcohol, exercise, nicotine, caffeine, others
  - EHRA Classification
  - Haemorrhagic Risk
  - Other Cardiac and PMH

Pathways

- FHFT Heart Failure Pathway
  - Red flags → refer to hospital urgently
    - Rapid worsening acute heart failure
    - Syncope / SOBAR / chest pain
    - Sustained symptomatic HR <60 / BP <90, Sats <90, HR >130
  - Suspected diagnosis
    - **ECG / BNP / CXR all patients**
    - BNP normal → consider alternate diagnosis
    - BNP >2000 → urgent referral
    - BNP 400-2000 → routine referral
  - Known diagnosis
    - Meds optimisation + self-management
    - Refer WPH Diuretic Lounge 07781 352511 / FPH 0300 613 6969
    - Refer Community Heart Failure team
    - Refer to IAPT for psychological support

Lipid-Lowering Medications

- Statins
  - Atorvastatin 1st / Rosuvastatin 2nd
  - First line for all hypercholesterolaemia
- Ezetimibe
  - Primary heterozygous-familial and non-familial hypercholesterolaemia
- Fibrates
  - Fenofibrate 1st / Bezafibrate 2nd
  - Indicated for hypertriglyceridaemia, not for primary CVD prevention
- Bempedoic Acid Tablets
  - Primary hypercholesterolaemia or mixed dyslipidemia
  - Only if no response to statins and ezetimibe
- Nicotinic Acid Group – Non-formulary
- Omega-3 Fatty Acids – Not recommended for CVD prevention
- Inclisiran Injection
  - Secondary prevention or familial hypercholesterolaemia
  - Consider if LDL-C ≥2.6 despite max tolerated lipid-lowering therapy
  - Subcutaneous injection at 3mths, then 6mthly
  - Cost can be claimed back by the practice / PCN
- PCSK9 Inhibitors (Alirocumab / Evolocumab Injections)
  - Prescribing restricted to secondary care specialist
  - Consider if LDL-C ≥3.5 despite ≥3 statins and ezetimibe

Frimley GP Guidance

Anticoagulation for Non-Valvular AF

- New QOF target!
- Offer anticoag if CHADS VASC ≥2 (consider if a score of 1 in males)
- DOACs are first line for NVAF unless:
  - Mechanical heart valve, moderate-severe aortic stenosis
  - Antiphospholipid syndrome, pregnant & breastfeeding
  - Creatinine clearance <15mls / min
  - Patient needs a INR >2
  - BMI >120kg or <50kg
  - ALT or AST >2x upper limit of normal, bilirubin >1.5x
  - Seek advice if on regular antivirals / anti-epileptics / erythromycin
- **Initiation: Weight, FBC, U&E, LFT and clotting**
- Monitoring: Annual FBC, U&E, weight, BP
- **Edoxaban 60mg OD or Apixaban 5mg BD are first line**
- Edoxaban 30mg if weight ≤60kg or CrCl 15-50
- Apixaban 2.5mg BD if ≥2/3: age >80, weight <60kg, creatinine >133
- Switching from warfarin:
  - Weight, FBC, U&E, LFT <3mths, calculate CrCl
  - INR <2.5 when warfarin is stopped and DOAC started

Frimley Lipid Management Tool

- Non-fasting lipids, U&E, TFT, LFT, and HbA1c for all
- Only measure CK if unexplained muscle pain before starting a statin
- LFT abnormality advice (<3x normal range is ok but monitor)
- Address modifiable risk factors (smoking / DM / obesity / alcohol / exercise / BP / HbA1c)
- Primary prevention
  - QRISK >10%, CKD ≥3, T1DM + >40yrs old, DM for >10yrs, nephropathy
  - Atorvastatin 20mg (rosuva 10mg if not tolerated – see intolerance pathway)
  - Aim for 50% reduction in LDL-C at 3mths (increase statin)
- Secondary prevention
  - Atorvastatin 80mg (if CKD ≥3 start at 20mg and titrate up)
  - Specialist advice needed if eGFR <30
  - If s/e reduce dose to 20mg and titrate back up
  - Rosuva 10mg second line
  - Add ezetimibe 10mg if <50% reduction in LDL-C at 3mths
  - Consider injectable therapy if fasting LDL-C ≥2.6 despite max tolerated statin + ezetimibe
- LFTs <3mths of initiation and any dose increase, then again at 12mths but not again unless clinically indicated
- Specialist referral
  - TC >7.5, LDL-C >4.9, non-HD >5.9 + personal or FH of CVD <60yrs old
  - Fasting triglycerides >10

Frimley Inclisiran GP Information

Wessex-Familial Hypercholesterolaemia (NEHF Section)

- Familial hypercholesterolaemia
  - Estimated to affect 1/250 but most remain undiagnosed
  - Untreated there is a high risk of early CVD
  - Treatment + healthy lifestyle can restore life expectancy to normal
  - Service aims to genetically identify affected individuals and their relatives by cascade testing
- New pt process
  - Referred to service
  - Counselled by FH specialist nurse
  - Genotype as appropriate
  - Cascade process
- Clinical criteria
  - Total Chol >7.5 + LDL-C >4.9 + Trig <5 + FH of premature MI or raised Chol