|  |  |  |
| --- | --- | --- |
| |  |  | | --- | --- | | ESC CONGRESS 2016 |  | |
| Doctor Richard Bogle (EUD ID : 156451) Epsom And St Helier University Hospitals Nhs Cardiology Wrythe Lane SM5 1AA - Carshalton United Kingdom Phone : +44 2082962782 - Fax : +44 2082963814 Email : richard.bogle@cardiac-report.com |
| |  |  | | --- | --- | |  | Agreement Form sent on 08/05/2016 01:09 | |  | The author agrees to transfer copyright to the ESC. | | Title : | Influence of national guidelines on the investigation of patients with suspected angina in a district hospital rapid access chest pain clinic | | Topic : | 04.06 - Angina pectoris stable | | Category : | Bedside | | Option : | Young Investigator Award (YIA) Population Sciences | |
| S. Khan1, B. Bradford1, S. John1, R. Paine1, J. Rogers1, RG. Bogle1 - (1) Epsom and St Helier University Hospitals NHS Trust, Carshalton, United Kingdom |
| |  | | --- | | Background: The Rapid Access Chest Pain Clinic (RACPC) is a "one-stop" clinic which is designed to identify patients with stable chest pain due to coronary artery disease (CAD) and reassure those with non-cardiac pain. Historically, patients were offered exercise treadmill testing (ETT) however in March 2010 the National Institute of Clinical and Healthcare Excellence (NICE) published guidelines recommending assessment of likelihood of CAD based on age, gender, chest pain type and risk factors followed by further assessment with either CT scanning (CT), functional imaging or invasive coronary angiography (ICA). This guideline discouraged the use of ETT in patients without known CAD. The current study investigated temporal trends in the investigation of patients referred to a district hospital RACPC before and after publication of the NICE guideline.  Methods: We performed a retrospective analysis of consecutive patients referred to our RACPC (Sep 08-Oct 15). We assessed likelihood of CAD according to NICE guideline which defined high risk as likelihood of CAD: >60%, intermediate risk: 30-60%, low risk: 11-29% and very low risk: <10%. We recorded choice of initial and any subsequent investigation requested from clinic and performed economic analysis using current UK tariff.  Results: Our cohort comprised 6815 patients; 28% had high likelihood of CAD, mandating ICA; 10.2% intermediate likelihood, mandating functional imaging; 11.5% low likelihood, mandating CT and 50.3% very low likelihood. We divided patients into chronological cohorts composed of consecutive patients (each cohort contained 1363 patients) which spanned periods prior to, and after publication of the NICE guideline. Prior to the NICE guideline 86% patients had an ETT which reduced to 72% post-NICE. Similarly, more patients were discharged with no investigation (12% pre-NICE vs 20% post). There was an increase in the overall number of patients referred for ICA (17% pre-NICE, 19% post), CT (0.4% pre-NICE to 4.4% post) and functional imaging (3.2% pre-NICE to 7.5% post). Overall the number of tests increased from 1.24 to 1.34 per patient post-NICE and the average cost per patient from £262 (€338) to £280 (€361). If the NICE guidelines were strictly applied to our population the average cost would have decreased by 39% to £172 (€222) per patient.  Conclusion: This is the largest study reporting temporal trends in assessment of patients in a RACPC . Since 2010 the NICE guidelines have been partial implemented with more non-cardiac chest pain patients being discharged without investigation. ETT was still used in many patients with atypical/typical angina to risk-stratify patients and there was a significant increase in the use of non-invasive imaging and ICA. Our results indicate that full implementation of the NICE guideline would result in less investigations and a more cost effective approach to the assessment of patients with suspected CAD. | |  | |  | |  | |

-