# ACACIA-HCM

## Aficamten for symptomatic non-obstructive hypertrophic cardiomyopathy

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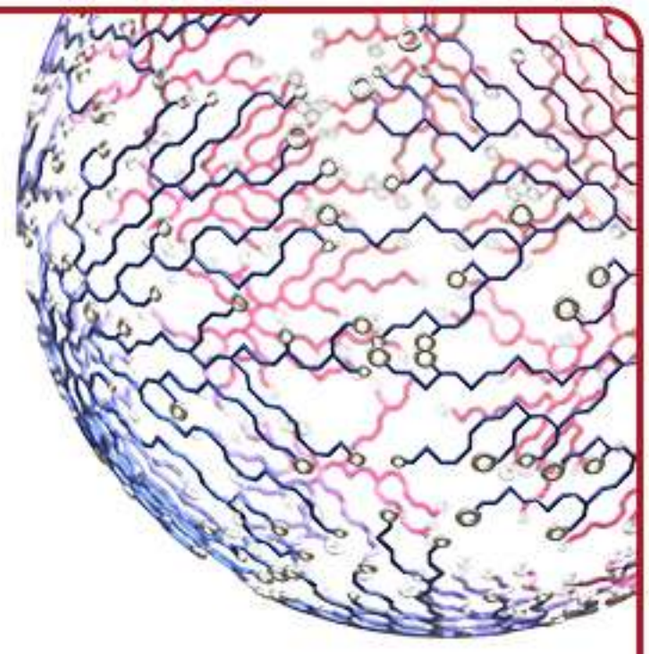
#ESCCongress



**Presenter:** Ahmad Masri (Oregon Health & Science University Medical Group - Portland, USA)

### Conclusion

Aficamten significantly improved symptom burden and exercise capacity vs placebo in patients with symptomatic non-obstructive hypertrophic cardiomyopathy (nHCM).

### Implications

This is the first trial to document therapeutic benefit for patients with nHCM.

## OBJECTIVE

To determine the effects of aficamten vs placebo on symptom burden and exercise capacity in patients with nHCM.

## METHODS

- Symptomatic nHCM

**517**
patients
randomised 1:1
182 centres worldwide

**Aficamten**
5–20 mg titrated at week 2, 4 and 6 based on LVEF

**Placebo**

→ 72 weeks

## RESULTS

| Primary endpoints | |
|---|---|
| **KCCQ-CSS improvement at 36 weeks**<br>• Aficamten: 11.4<br>• Placebo: 8.4 | ↑ p=0.02 |
| **pVO2 change (mL/kg/min) at 36 weeks**<br>• Aficamten: 0.64<br>• Placebo: –0.03 | ↑ p=0.003 |

# CARDIO-TTRansform

## Efficacy and safety of eplontersen in patients with transthyretin amyloid cardiomyopathy (ATTR-CM)

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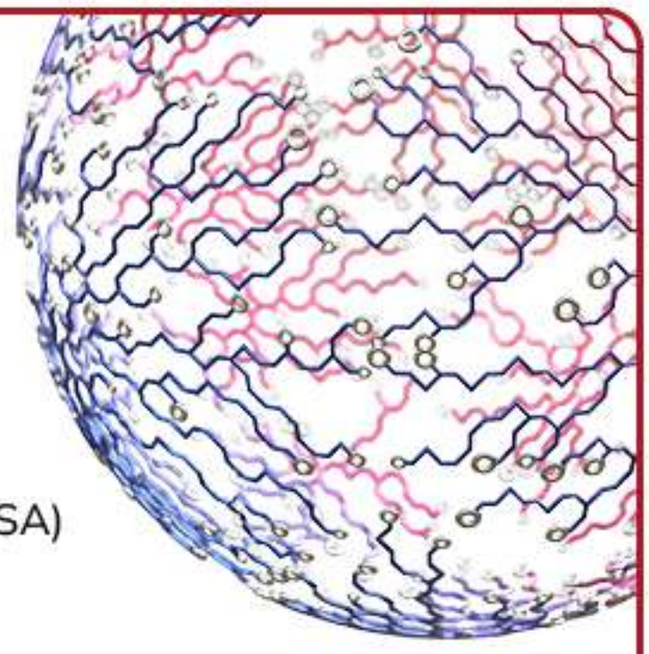

**Presenter:** Mathew Maurer (Columbia University Irving Medical Centre - New York, USA)

### Conclusion

Eplontersen did not significantly reduce the primary endpoint of CV mortality and recurrent CV events vs placebo at 140 weeks.

### Implications

These findings will inform clinical practice and the evaluation of TTR-lowering treatment strategies in ATTR-CM.

## OBJECTIVE

To assess the efficacy and safety of eplontersen in patients with ATTR-CM.

## METHODS

- Variant or wild-type ATTR-CM
- Receiving SoC

**1,432**
patients
randomised 1:1
130 sites in 20 countries

- **Eplontersen 45 mg SC Q4W**
- **Placebo SC Q4W**

## RESULTS

| Overall | Eplontersen | Placebo | |
|---|---|---|---|
| **Primary endpoint**<br>CV mortality and recurrent CV events at 140 weeks | 381 events in 210 patients | 392 events in 231 patients | Rate ratio 0.89<br>95% CI 0.73–1.09<br>p=0.277 |

- No clear benefit in patients receiving background stabiliser therapy
- Fewer primary endpoint events with eplontersen vs placebo in patients not receiving a stabiliser

# CMR GUIDE

## CMR-guided management of mild–moderate left ventricular systolic dysfunction with an ICD

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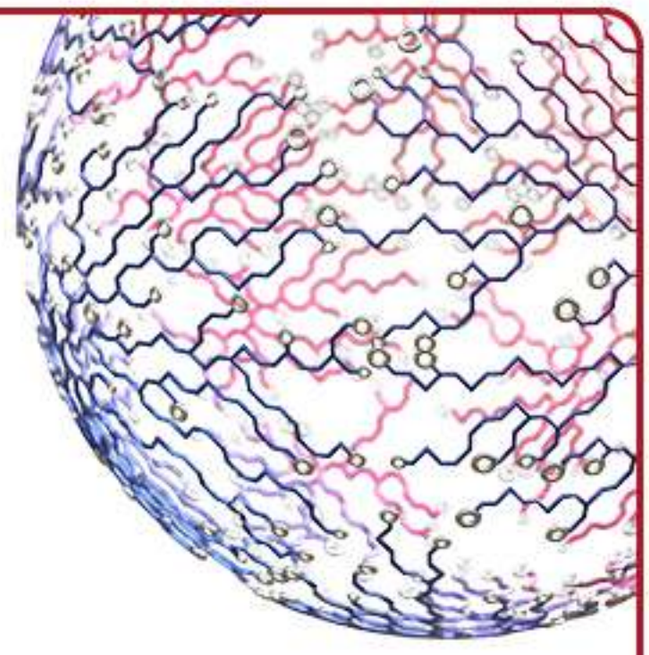

**Presenter:** Joseph Selvanayagam (Flinders University - Adelaide, Australia)

### Conclusion

In patients with LVEF 36–50% and myocardial scar, an ICD had no effect on sudden cardiac death (SCD) or haemodynamically significant ventricular arrhythmia (HSVA) overall but did reduce risk in younger patients.

### Implications

These data could be used in shared decision-making with patients.

## OBJECTIVE

To determine whether ICD therapy guided by the presence of myocardial scar on CMR can reduce rates of SCD or HSVA in patients with LVEF 36–50%.

## METHODS

- LVEF 36–50%
- LGE-CMR-defined myocardial scar

**353** patients randomised 1:1

18 sites in 3 countries

**Single-chamber ICD**

**Implantable loop recorder (ILR)**

**Primary endpoint:** SCD or HSVA

Median follow-up: 6 years

## RESULTS

| Primary endpoint | | ICD | ILR |
|---|---|---|---|
| Overall | 0.76; 95% CI 0.37–1.58 | **7.8%** | 9.2% |

Patients aged <70 years: **Significant 72% reduction**

Patents aged ≥70 years: **No benefit**

# POET-II

## Response-tailored duration of antibiotic treatment for infectious endocarditis

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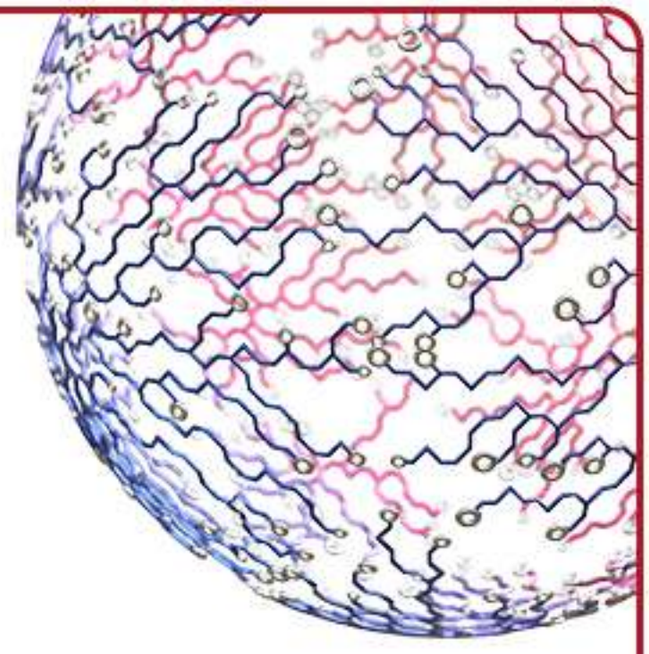

**Presenter:** Henning Bundgaard (Rigshospitalet - Copenhagen University Hospital - Copenhagen, Denmark)

### Conclusion

A tailored strategy shortened antibiotic duration by 2 weeks vs standard therapy, with no major safety concerns.

### Implications

A shorter course of antibiotics has many advantages for patients and for the healthcare system.

## OBJECTIVE

To investigate whether tailoring antibiotic therapy in those who have an initial response using the POET criteria safely reduces the duration of antibiotics.

## METHODS

- Left-sided infectious endocarditis
- *S. aureus*, *E. faecalis* or streptococci infection
- Stabilised based on the POET criteria

**508**
patients
randomised 1:1
13 centres in
Denmark, Sweden and US

**Tailored**
based on response

Antibiotics for
minimum 2–4 weeks

**Standard**

Antibiotics for 4–6 weeks

## RESULTS

| | Tailored duration | Standard duration | |
|---|---|---|---|
| **Median duration of antibiotics** | 26 days ↓ | 41 days | p<0.001 |
| **Primary endpoint**<br>Median number of days alive without antibiotic treatment within 6 months after randomisation | 183 days ↑ | 169 days | p<0.001 |
| **Safety endpoint**<br>All-cause mortality, unplanned heart valve surgery or symptomatic embolic events | 8.2% ↔ | 10.7% | Noninferior |

# SINGLE-AF

## Anticoagulation for atrial fibrillation with intermediate stroke risk

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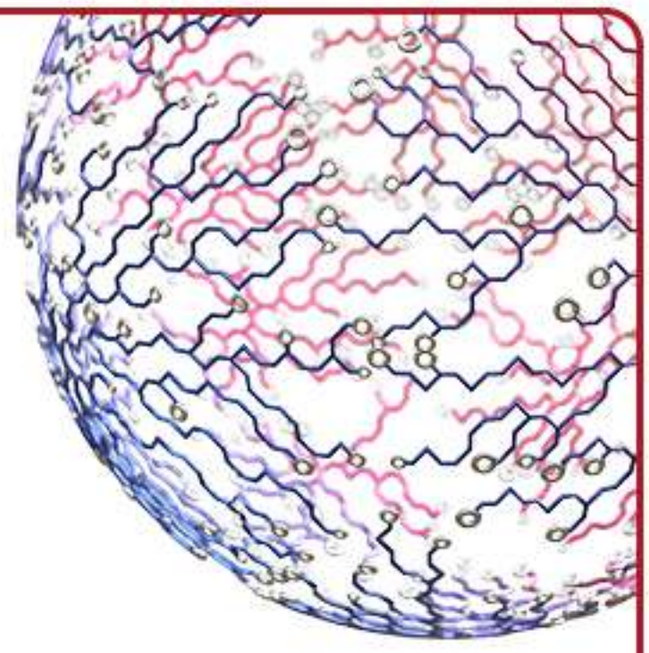

**Presenter:** Boyoung Joung (Yonsei University - Seoul, South Korea)

### Conclusion

Among patients with AF and intermediate stroke risk, DOAC therapy lowered the risk of stroke, systemic embolism, major bleeding or CV death at 2 years vs no DOACs.

### Implications

This first randomised trial demonstrates the benefits of DOACs in patients with AF at intermediate stroke risk.

## OBJECTIVE

To investigate whether DOACs can reduce adverse clinical events in patients with AF and intermediate stroke risk vs no DOACs.

## METHODS

- AF
- CHA2DS2-VASc:
  men=1
  women=2

**1,803**
patients
randomised 1:1
18 centres in
South Korea

DOAC

No DOAC

2 years

## RESULTS

| | DOAC | No DOAC |
|---|---|---|
| **Primary endpoint at 2 years**<br>Stroke, systemic embolism, major bleeding or CV death | 0.5% | 1.5% |
| | HR 0.31<br>95% CI 0.10–0.94<br>p=0.028 | |
| Major bleeding at 2 years | 0.3% | 0.5% |

# AMUNDSEN

## Evolocumab before PCI for acute MI

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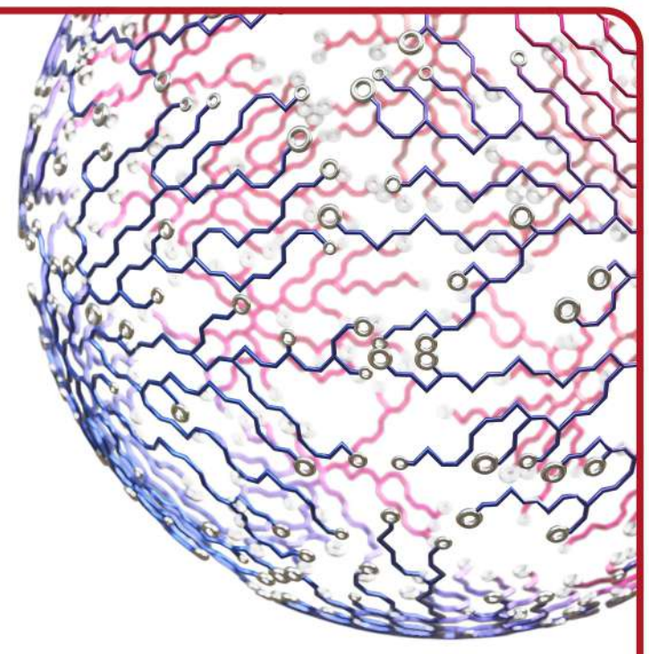

**Presenter:** Gilles Montalescot (Sorbonne University - Paris, France)

### Conclusion

Evolocumab administered before PCI improved LDL-C goal attainment but did not significantly reduce the main clinical CV outcome at 1 year.

### Implications

Additional strategies are needed to reduce recurrent CV events after MI.

## OBJECTIVE

To compare evolocumab prior to PCI vs standard care in high-risk patients admitted to hospital with an MI.

## METHODS

- STEMI undergoing primary PCI or NSTEMI indicated for PCI
- ≥1 high-risk characteristic

**2,161** patients randomised 1:1

48 centres in 6 countries

- **Evolocumab**
- **Standard care**

## RESULTS

| At 12 months | Evolocumab | Standard care | |
|---|---|---|---|
| **Primary endpoint** LDL-C reduction ≥50% and <55 mg/dL | **82.0%** ↑ | 40.0% | p<0.001 |
| **Main clinical endpoint** All-cause death or unplanned CV hospitalisations | **14.6%** ↔ | 15.4% | |

# DAN-RSV

## RSV prefusion F protein–based vaccine (RSVpreF) for preventing cardiorespiratory hospitalisations

**Presenter:** Tor Biering-Sorensen (Gentofte University Hospital - Copenhagen, Denmark)

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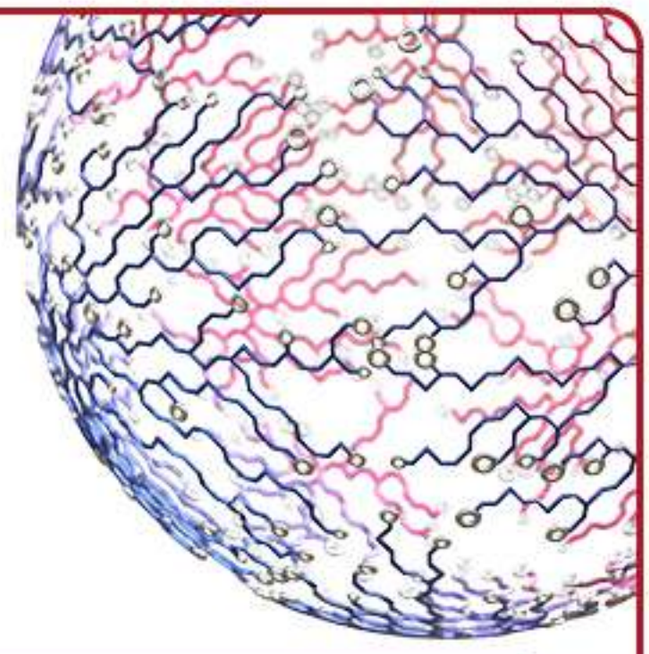
#ESCCongress



### Conclusion

Vaccination against respiratory syncytial virus (RSV) reduced RSV-related and cardiorespiratory hospitalisations during the first RSV season after vaccination.

### Implications

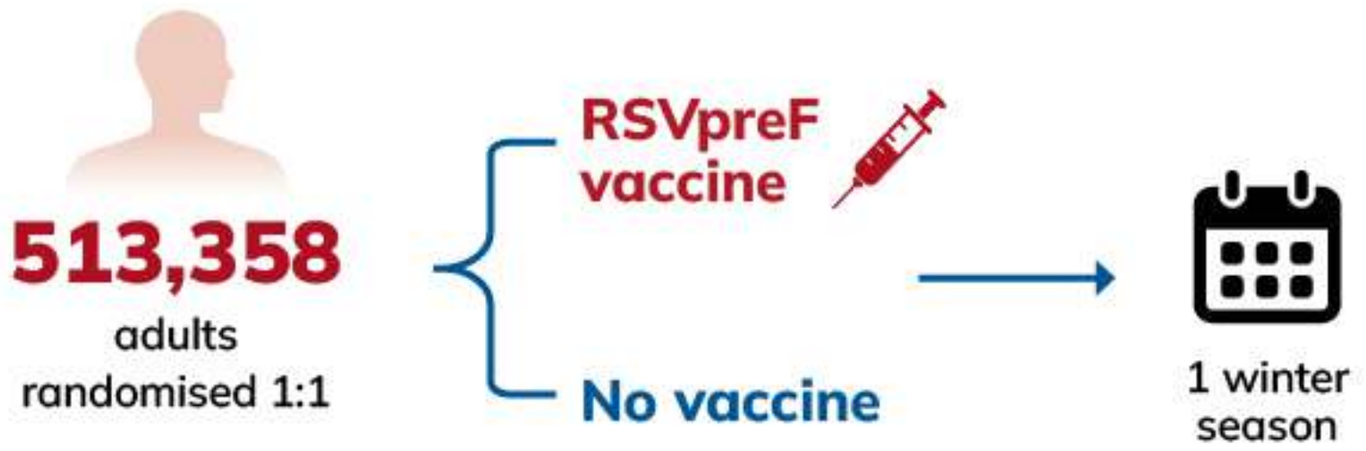
These findings provide randomised evidence supporting RSVpreF vaccination for preventing severe RSV-related disease and suggest broader benefits for cardiorespiratory health.

## OBJECTIVE

To evaluate the effectiveness of a bivalent RSV prefusion F protein–based vaccine (RSVpreF) in preventing RSV-related hospitalisations among adults.

## METHODS

- Ongoing pragmatic trial
- Conducted using integrated public healthcare registries in Denmark and Spain




## RESULTS

| | RSVpreF | No vaccine | Vaccine effectiveness |
|---|---|---|---|
| Hospitalisations for RSV-related respiratory tract disease per 1,000 PY | 0.2 | 0.6 | 70.3% |
| Hospitalisations for any cardiorespiratory disease per 1,000 PY | 23.4 | 24.9 | 6.2% |

# ENRICH-AF

## Edoxaban in intracranial haemorrhage survivors with AF

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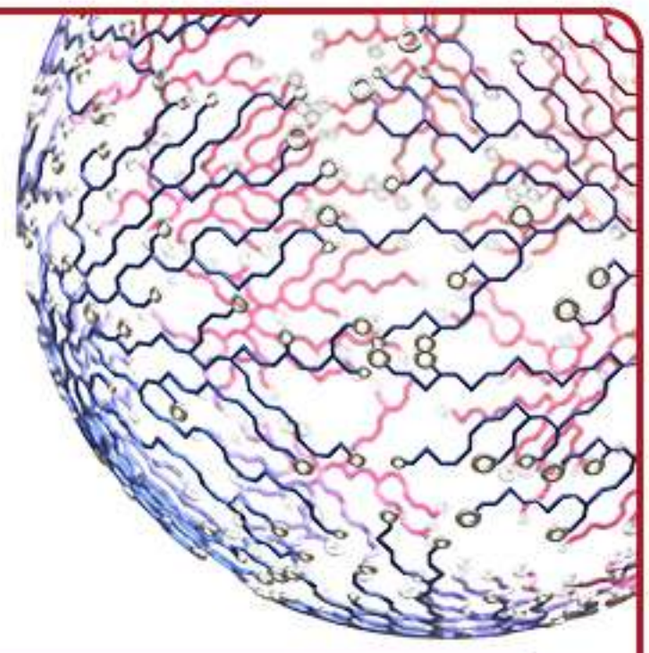

**Presenter:** Ashkan Shoamanesh (McMaster University - Hamilton, Canada)

### Conclusion

Edoxaban did not reduce stroke or systemic embolism and increased major bleeding in AF patients with prior intracranial haemorrhage.

### Implications

Safer stroke-prevention strategies are required in this vulnerable population.

## OBJECTIVE

To evaluate the efficacy and safety of oral anticoagulation in high-risk patients with AF and prior intracranial haemorrhage.

## METHODS

- High-risk AF
- Prior intracranial haemorrhage

**948**
patients randomised 1:1
174 sites in 20 countries

- **Edoxaban**
- **No anticoagulation**

Average follow-up: 28 months

## RESULTS

| Primary endpoints | Edoxaban | | No anticoagulation | |
|---|---|---|---|---|
| Efficacy: Stroke or systemic embolism | 11.8% | ⟷ | 12.8% | p=0.48 |
| Safety: ISTH major bleeding | 11.6% | ↑ | 5.2% | p<0.001 |

# REACT

## Prevalence of silent atherosclerosis across adult life

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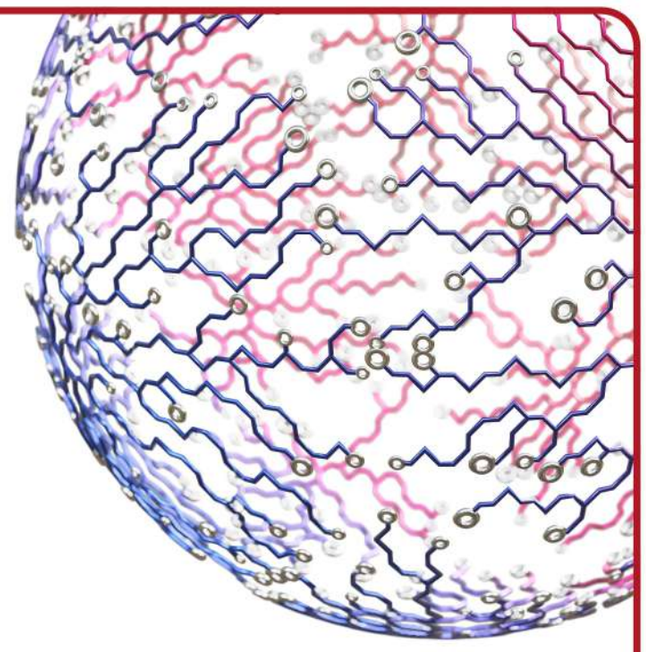

**Presenter:** Henning Bundgaard (Rigshospitalet - Copenhagen University Hospital - Copenhagen, Denmark)

### Conclusion

Silent atherosclerosis was detected in young adults without known ASCVD and increased in prevalence in a sigmoid curve to very high levels in older individuals.

### Implications

Early imaging-based detection of atherosclerosis may help to improve targeting of primary prevention.

## OBJECTIVE

To create a large-scale atlas of silent atherosclerosis using different imaging modalities in multiple vascular beds, across the adult lifespan.

## METHODS

- 18–70 years old
- No known ASCVD

**16,808**
individuals

4 sites in Denmark
4 sites in Spain

**Imaging**

Vascular ultrasound of carotid and femoral arteries

Coronary CT angiography

Presence of silent atherosclerosis

## RESULTS

### Presence of silent atherosclerosis

**All participants**

**57.1%**

**By age**

**~8%**
18–29 year olds

**>90%**
With multiterritorial involvement
60–70 year olds

**By sex**

**63.4%**
Increased from third decade in men

**50.9%**
Increased after 40 years in women

# STAREE

## Statins for reducing events in the elderly

**Presenter:** Sophia Zoungas (Monash School of Public Health and Preventive Medicine - Melbourne, Australia)

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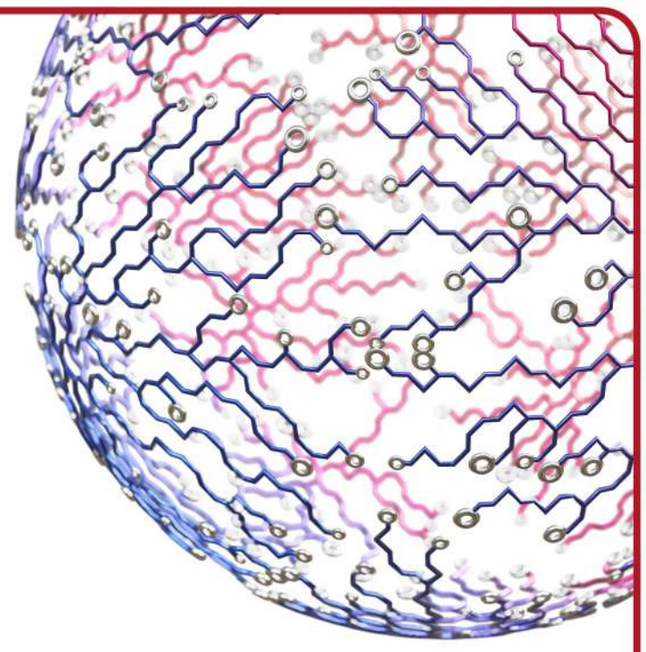

### Conclusion

Atorvastatin significantly reduced major CV events but did not significantly improve disability-free survival vs placebo in older people without known CVD, diabetes and dementia.

### Implications

These data may inform guidelines to help improve CV risk management in older people.

## OBJECTIVE

To assess the use of atorvastatin for primary prevention in older individuals.

## METHODS

- ≥70 years of age
- No known CVD, diabetes and dementia

**9,971** patients randomised 1:1

GP practices in Australia

**Atorvastatin 40 mg**

**Placebo**

Median follow-up: 5.9 years

## RESULTS

| Primary endpoints | Atorvastatin | Placebo | |
|---|---|---|---|
| CV death, nonfatal MI, stroke or coronary revascularisation | 6.0% ↓ | 8.3% | HR 0.70<br>95% CI 0.61–0.82 |
| Death, dementia or persistent physical disability | 12.8% ↔ | 13.6% | HR 0.94<br>95% CI 0.84–1.05 |

# TRANQUILITY

## Pacibekitug (IL-6 ligand mAb) in patients with CKD and high CV risk

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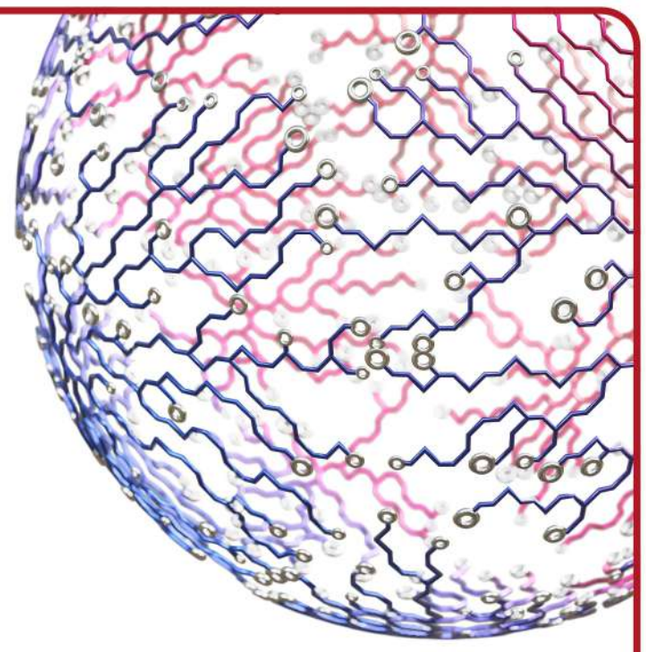


**Presenter:** Deepak Bhatt (Icahn School of Medicine at Mount Sinai - New York City, USA)

### Conclusion

Pacibekitug caused sustained decreases in hsCRP up to day 180 with no clear dose-related safety signals observed.

### Implications

The results of this phase II trial support clinical evaluation of pacibekitug in a CV outcomes trial.

## OBJECTIVE

To evaluate the long-acting anti–IL-6 mAb pacibekitug in patients with CKD and elevated hsCRP.

## METHODS

- Stage 3 or 4 CKD
- Elevated hsCRP (2 to <15 mg/L)

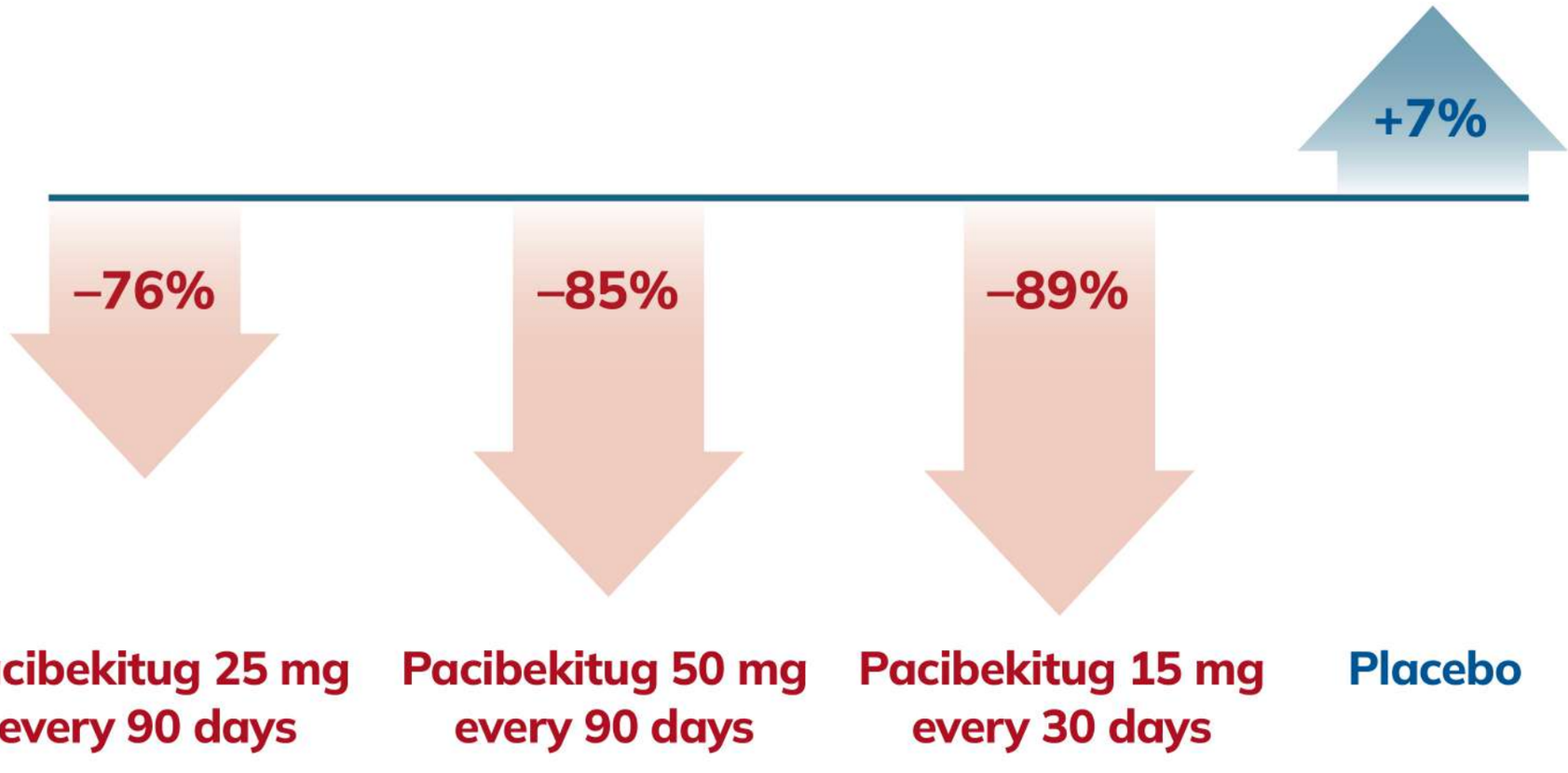
**143** patients randomised 1:1:1:1

49 centres in USA

- **Pacibekitug SC 25 mg every 90 days**
- **Pacibekitug SC 50 mg every 90 days**
- **Pacibekitug SC 15 mg every 30 days**
- **Placebo SC**

## RESULTS

**Primary endpoint:** Time-averaged percent change from baseline in hsCRP to day 180



# A-CLOSE

## Clopidogrel vs extended DAPT after high-risk PCI

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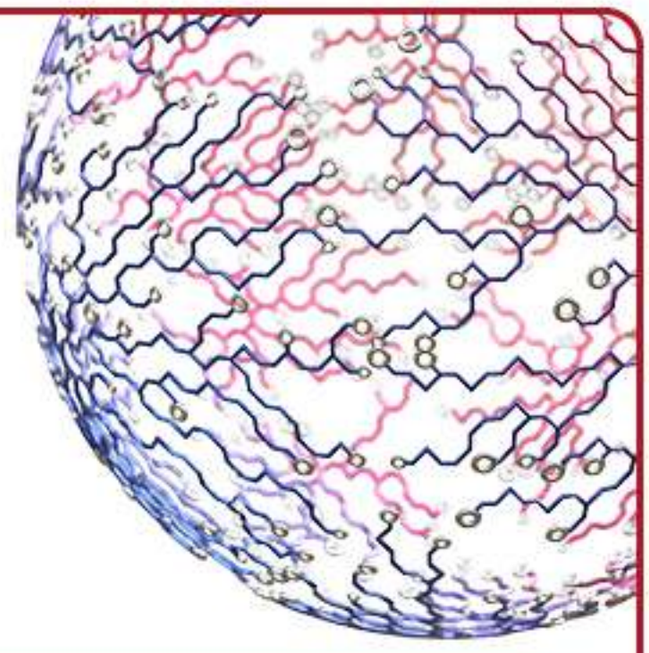

**Presenter:** Byeong-Keuk Kim (Severance Cardiovascular Hospital, Yonsei University College of Medicine - Seoul, South Korea)

### Conclusion

Among high-risk patients 12 months after PCI with DES, clopidogrel monotherapy lowered bleeding risk while DAPT lowered ischaemic risk.

### Implications

An individualised approach to long-term antiplatelet therapy is warranted.

## OBJECTIVE

To evaluate whether clopidogrel monotherapy is noninferior to extended DAPT for ischaemic and bleeding events over 24 months.

## METHODS

- PCI with DES
- High-risk features

DAPT for 12 months

**3,203** patients randomised 1:1

19 centres in South Korea

**Clopidogrel**

**DAPT: Clopidogrel + aspirin**

24 months

**Primary endpoint:** Death, MI, stent thrombosis, stroke or BARC 2, 3 or 5 bleeding

## RESULTS

| | Clopidogrel vs DAPT | |
|---|---|---|
| **Primary endpoint after 24 months** | 5.0% vs 5.1% | p=0.001 for noninferiority |
| **Ischaemic components** | 3.7% vs 1.6% | p<0.001 |
| **Bleeding components** | 1.8% vs 4.1% | p<0.001 |

# EPIDAURUS

## Escalated P2Y12 inhibition in ACS and AF

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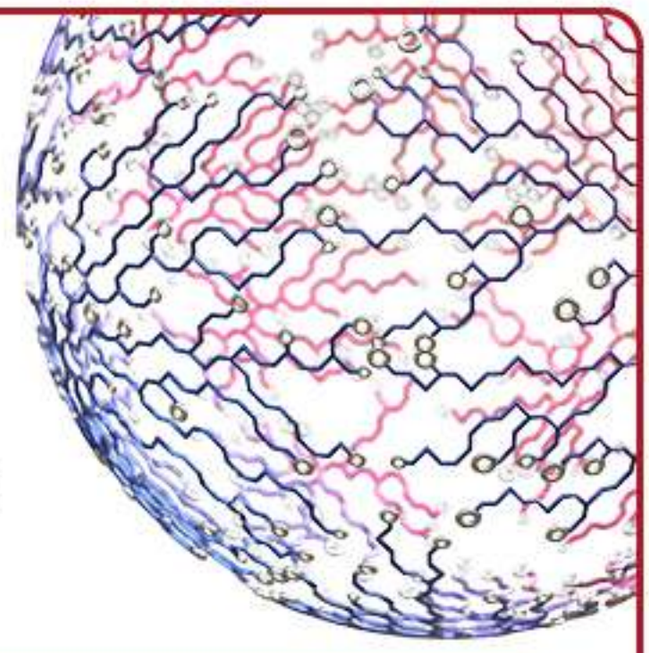

**Presenter:** Konstantinos D Rizas (Ludwig Maximilians University - Munich, Germany)

### Conclusion

Escalated P2Y12-inhibition was associated with higher bleeding rates, with no evidence of reduced ischaemic events.

### Implications

The trial was stopped early due to safety concerns.

## OBJECTIVE

To compare the efficacy and safety of escalated potent P2Y12 inhibition vs clopidogrel, with DOAC, in patients with ACS and AF undergoing PCI.

## METHODS

- ACS
- AF requiring OAC
- Undergoing PCI

**602**
patients randomised 1:1
33 centres in Austria and Germany

**Prasugrel or ticagrelor**

Plus DOAC for 4 weeks

**Clopidogrel**

**Primary efficacy and safety endpoints:**
6 weeks

## RESULTS

| Primary endpoints at 6 weeks | Prasugrel/ticagrelor vs clopidogrel |
|---|---|
| **Efficacy**<br>Death, stent thrombosis, MI, stroke, systemic thromboembolism and urgent revascularisation | **HR 0.86**<br>95% CI 0.44–1.67; p=0.649 |
| **Safety**<br>BARC ≥3 bleeding | **HR 3.54**<br>95% CI 1.15–10.85; p=0.028 |

# LIBREXIA ACS

## Milvexian after recent ACS

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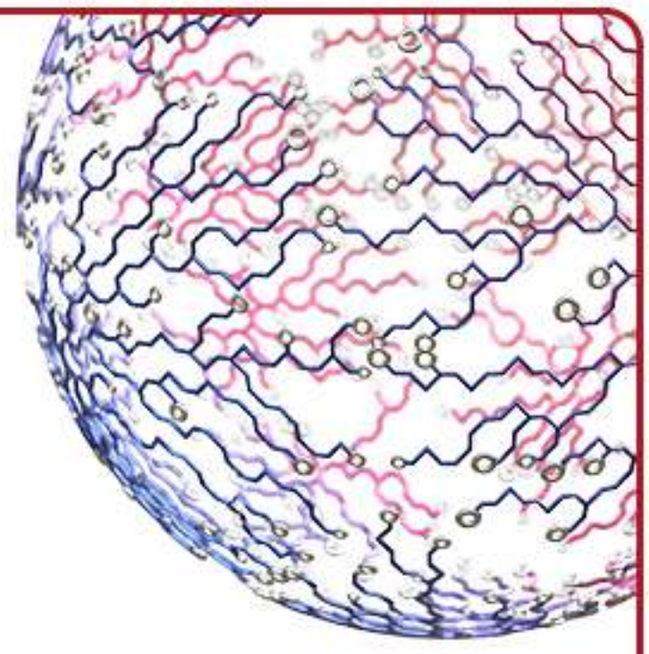

**Presenter:** Philippe Gabriel Steg
(Hôpital Bichat-Claude Bernard - Paris, France)

### Conclusion

Milvexian did not reduce recurrent CV events compared with placebo after recent ACS.

### Implications

The findings do not support adding milvexian after recent ACS to reduce recurrent CV events.

## OBJECTIVE

To assess the efficacy and safety of the selective factor XIa inhibitor, milvexian, after ACS.

## METHODS

- ACS within 7 days
- ≥2 risk-enhancing factors

**14,194**
patients
randomised 1:1

893 sites in 44 countries

- **Milvexian 25 mg twice daily**
- **Placebo**

## RESULTS

| Median follow-up: 10 months | Milvexian | Placebo | |
|---|---|---|---|
| **Primary efficacy endpoint** Cardiovascular death, MI or ischaemic stroke | 5.4% | 5.1% | HR 1.05; 95% CI 0.91–1.21; p=0.50 |
| **Principal safety endpoint** BARC 3c or 5 bleeding | 0.3% | 0.3% | HR 1.04; 95% CI 0.58–1.87; p=0.88 |

# PREMIUM

## Aspirin omission at the time of primary PCI in STEMI

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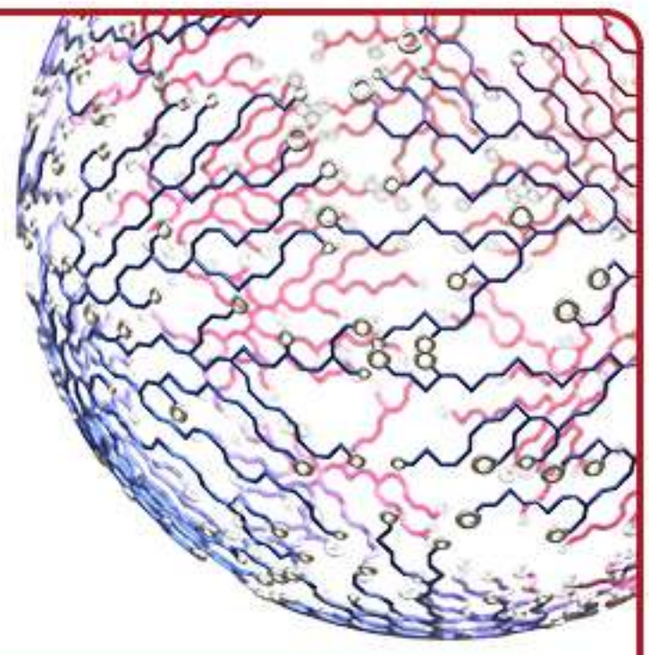

**Presenter:** Gaku Nakazawa (Kindai University - Osaka, Japan)

### Conclusion

Prasugrel monotherapy failed to show noninferiority to DAPT for any-cause death, MI or stroke after 12 months.

### Implications

Upfront aspirin omission does not appear to be feasible in STEMI patients undergoing PCI.

## OBJECTIVE

To determine whether prasugrel monotherapy without aspirin is noninferior to DAPT in patients with STEMI undergoing PCI.

## METHODS

- STEMI undergoing primary PCI

**2,280** patients randomised 1:1
69 centres in Japan

**Prasugrel monotherapy**

**Aspirin plus prasugrel**

**Primary endpoint:** Any-cause death, MI or stroke at 12 months

## RESULTS

| | Prasugrel vs DAPT |
|---|---|
| **Primary endpoint after 12 months** | **11.0%** vs **8.5%**<br>HR 1.34; 95% CI 1.02–1.75<br>p=0.40 for noninferiority |
| **Major bleeding** | **5.6%** vs **8.4%**<br>HR 0.66; 95% CI 0.47–0.91 |

# SWITCH SWEDEHEART

## Switching from ticagrelor to prasugrel in patients with ACS

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**Presenter:** Elmir Omerovic (Sahlgrenska University Hospital - Gothenburg, Sweden)

### Conclusion

A default prasugrel policy yielded similar ischaemic outcomes as ticagrelor and lower bleeding in an unselected ACS population undergoing PCI.

### Implications

SWITCH SWEDEHEART demonstrates the feasibility of large-scale, registry-based randomised evidence generation.

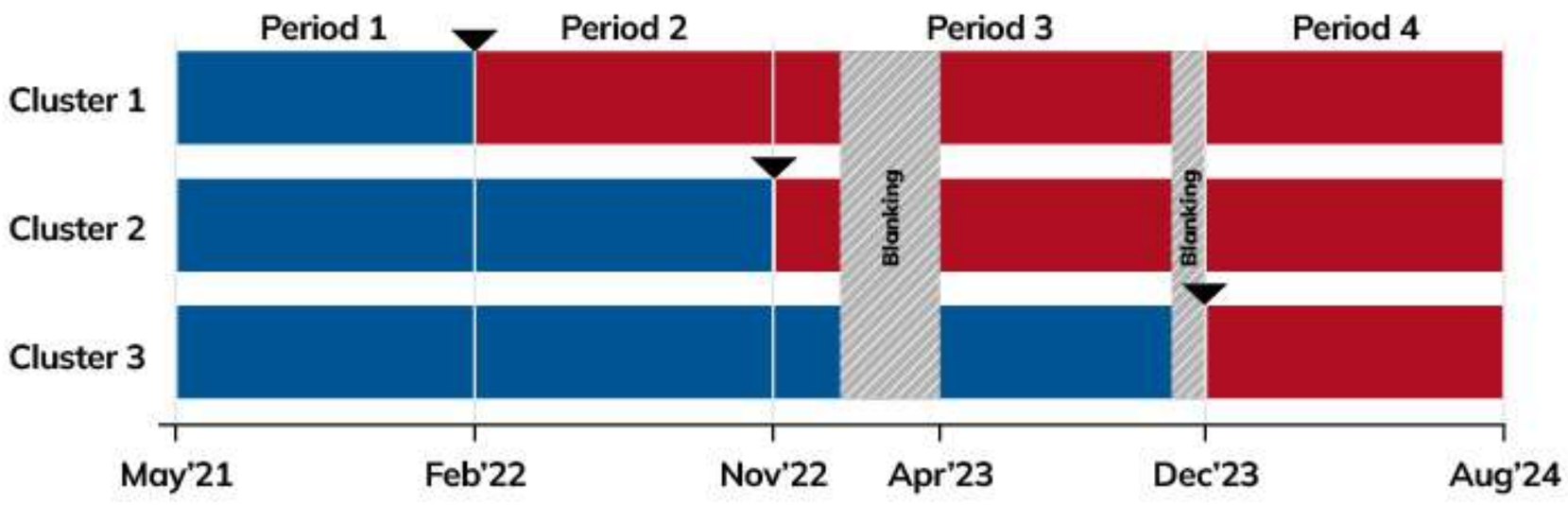
## OBJECTIVE

To establish the optimal P2Y12 inhibitor for unselected patients with ACS undergoing PCI.

## METHODS

- SWEDEHEART national registry
- 17,095 patients
- ACS
- PCI

7 regions grouped into 3 clusters sequentially switched from a **ticagrelor policy** to a **prasugrel policy**




## RESULTS

| | Prasugrel policy | Ticagrelor policy | |
|---|---|---|---|
| **Primary endpoint at 1 y**<br>Death, MI, stroke | 11.1% | 11.8% | p=0.22 |
| Major bleeding at 1 y | 4.2% | 4.4% | p=0.042 |

# AIR-STEMI

## Functional coronary angiography in STEMI

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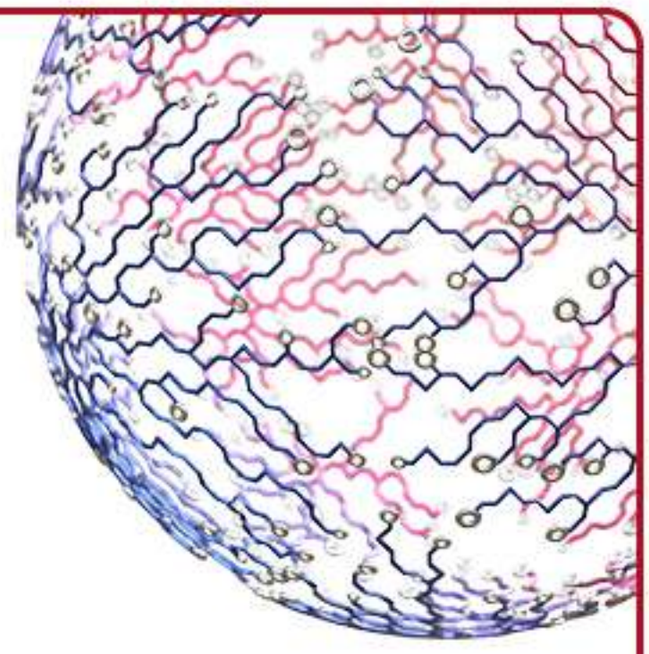

**Presenter:** Simone Biscaglia (University Hospital of Ferrara - Ferrara, Italy)

### Conclusion

Complete revascularisation guided by functional coronary angiography reduced CV events vs conventional angiography in patients with STEMI and multivessel disease.

### Implications

AIR-STEMI establishes an optimal strategy for managing non-culprit lesions in multivessel disease.

## OBJECTIVE

To test whether functional coronary angiography can improve the management of non-culprit lesions in STEMI patients with multivessel disease.

## METHODS

- STEMI and multivessel disease
- Successful culprit-lesion PCI

**1,823**
patients randomised 1:1
21 centres in Italy and Pakistan

**Functional coronary angiography**
PCI only for functionally significant lesions

**Conventional angiography**
PCI of all non-culprit lesions angiographically deemed ≥50%

No PCI

## RESULTS

| Median follow-up: 17.9 months | Functional coronary angiography | Conventional angiography | |
|---|---|---|---|
| **Primary endpoint**<br>All-cause death, MI, CVA or ischaemia-driven coronary revascularisation | 8.9% | 13.7% | HR 0.62<br>95% CI 0.47–0.83;<br>p<0.001 |
| Acute kidney injury or major bleeding | 4.6% | 7.1% | HR 0.63<br>95% CI 0.43–0.93;<br>p=0.02 |

# PRESC1SE-MI and IPD meta-analysis

## Safety and efficacy of the 0/1-hour algorithm

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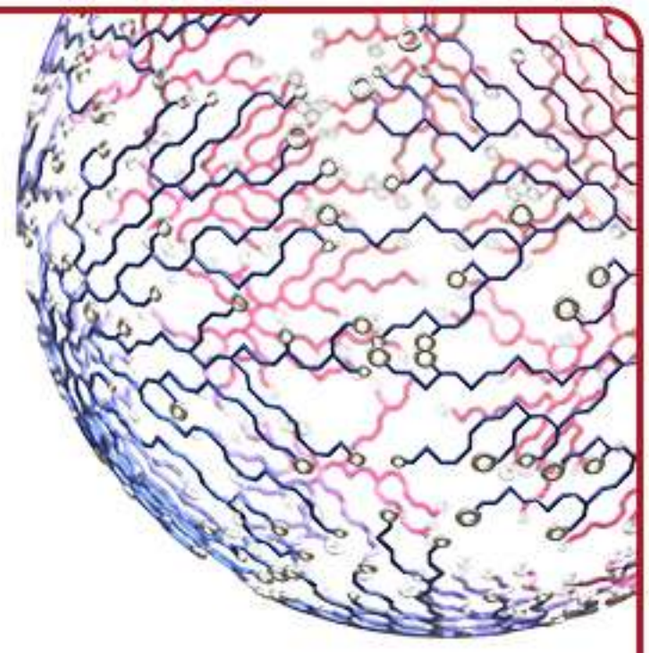
#ESCCongress



**Presenters:** Jasper Boeddinghaus and Christian Mueller
(University Hospital Basel - Switzerland)

### Conclusion

The 0/1-hour pathway was noninferior to the 0/3-hour pathway for safety but did not reduce the ED length of stay in patients with suspected MI.

### Implications

Healthcare providers should be aware of the implementation barriers when considering adopting rapid pathways in practice.

## OBJECTIVE

To assess the safety and efficacy of the 0/1-hour vs 0/3-hour pathway in hospitals that have not yet adopted the faster strategy.

## PRESC1SE-MI trial

**67,624**
patient presentations to ED with suspected MI

Stepped-wedge cluster randomised trial

20 hospitals who had not adopted the 0/1-hour pathway

**Switch to 0/1-hour pathway**

**Remain on 0/3-hour pathway**

| Co-primary endpoints | 0/1-hour pathway | 0/3-hour pathway | |
|---|---|---|---|
| Death or new type 1 MI in 30 days, % | 1.1 | 1.2 | p for noninferiority <0.001 |
| ED length of stay, minutes | 309 | 309 | p=0.65 |

## IPD meta-analysis

- PRESC1SE-MI plus 4 other trials: 110,933 patient presentations
- **Results were consistent with PRESC1SE-MI**

# TARGET-CTCA

## Troponin in acute chest pain to guide CTCA

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**Presenter:** Nicholas Mills (University of Edinburgh - Edinburgh, UK)

### Conclusion

CTCA did not reduce subsequent MI or cardiac death compared to standard care in intermediate-risk patients with suspected ACS where MI was excluded.

### Implications

Implementing CTCA to guide management in this patient population is not warranted based on these findings.

## OBJECTIVE

To determine if patients with suspected ACS where a MI had been ruled out but who were at intermediate risk based on hs-cTn testing could benefit from CTCA.

## METHODS

- Suspected ACS
- MI ruled out
- Intermediate risk based on hs-cTn

**3,170** patients randomised 1:1

14 hospitals in UK

**CTCA + SoC**

**SoC**

**Primary endpoint:**

MI or cardiac death

Median follow-up: 3 years

## RESULTS

- CTCA added to SoC did not reduce rates of MI or cardiac death:

| CTCA + SoC: 7.0% | SoC: 7.3% | Adjusted HR 0.95<br>95% CI 0.73–1.23; p=0.712 |
|---|---|---|

# ADHERE-ASCVD

## Adaptive digital outreach for statin adherence

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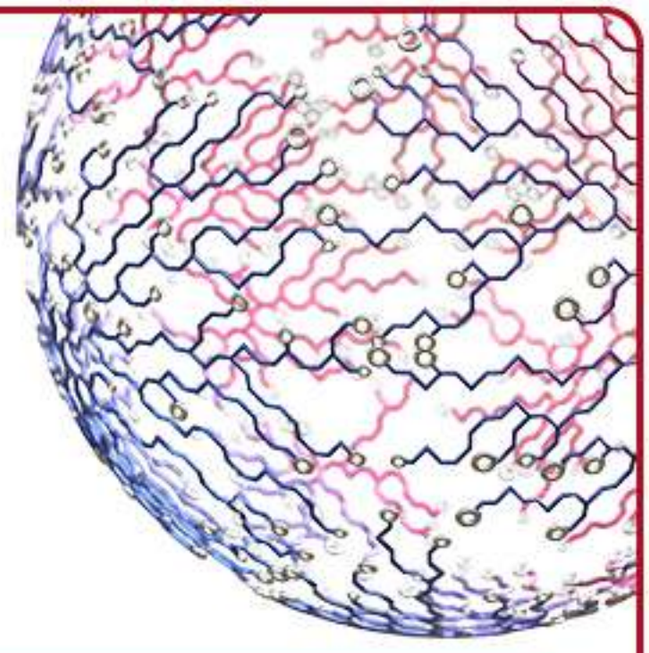
#ESCCongress



**Presenter:** Ankeet S. Bhatt (Kaiser Permanente SF Medical Center & Division of Research - San Francisco, USA)

### Conclusion

Digital outreach improved short-term statin refill compared with usual communication. Second outreach produced additional gains among initial non-responders, although switching was no more effective than repeating the same modality.

### Implications

These findings support scalable, adaptive health system outreach strategies to close gaps in CV prevention.

## OBJECTIVE

To evaluate digital outreach modalities to improve statin refill among patients with low adherence.

## METHODS

- With or at high risk of ASCVD
- Low statin adherence

**20,604** patients randomised 1:1:1:1

Single US integrated health system

**Stage 1**

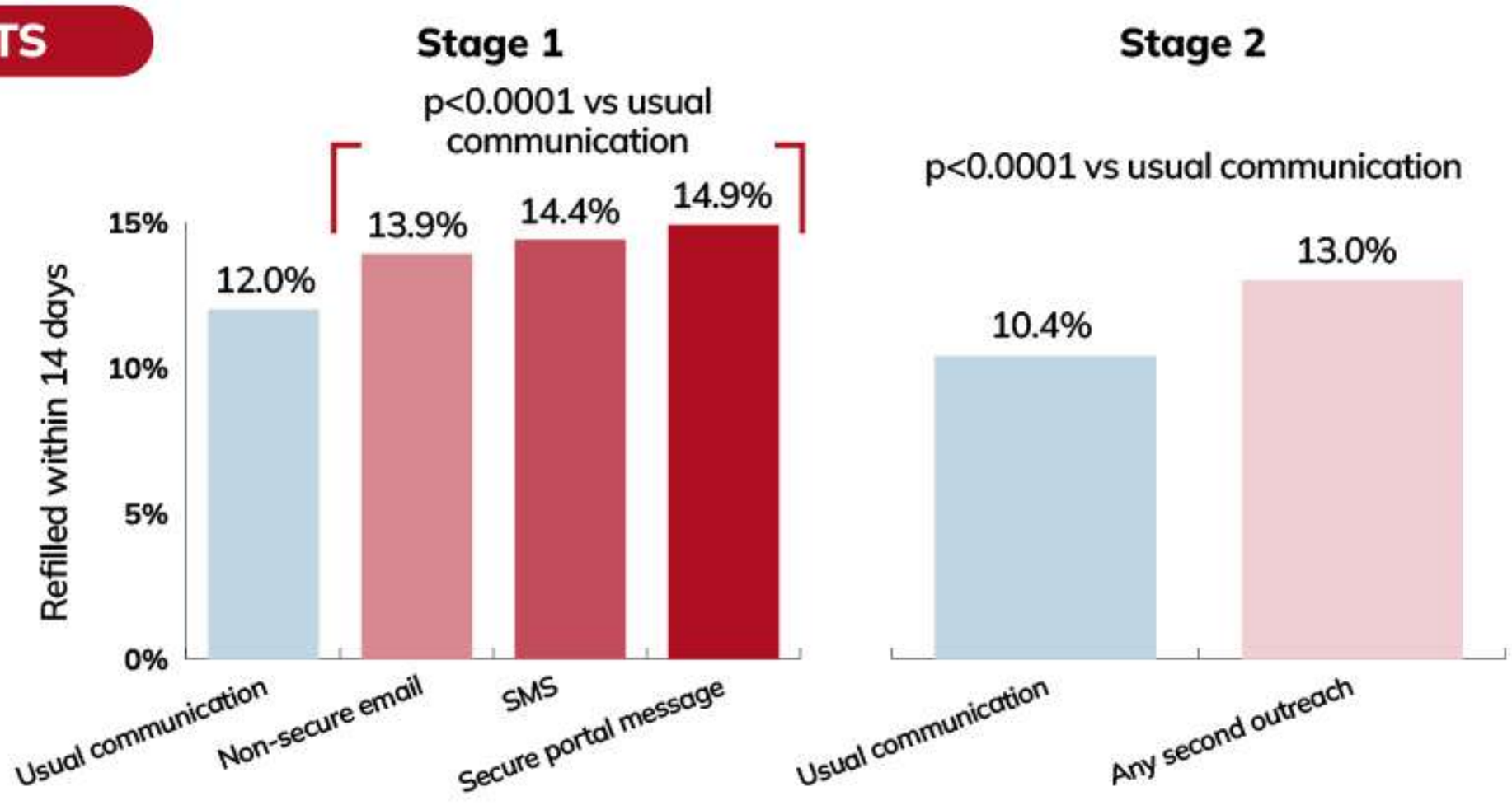
- Non-secure email
- SMS text
- Secure portal message
- Usual communication

→ **Primary endpoint:** Refilled within 14 days →

**Stage 2**

**Non-responders** randomised to the same or switched digital outreach or usual communication

## RESULTS



# EMAIL-HF

## Implementation of SGLT2 inhibitors in patients with HF through a digital strategy

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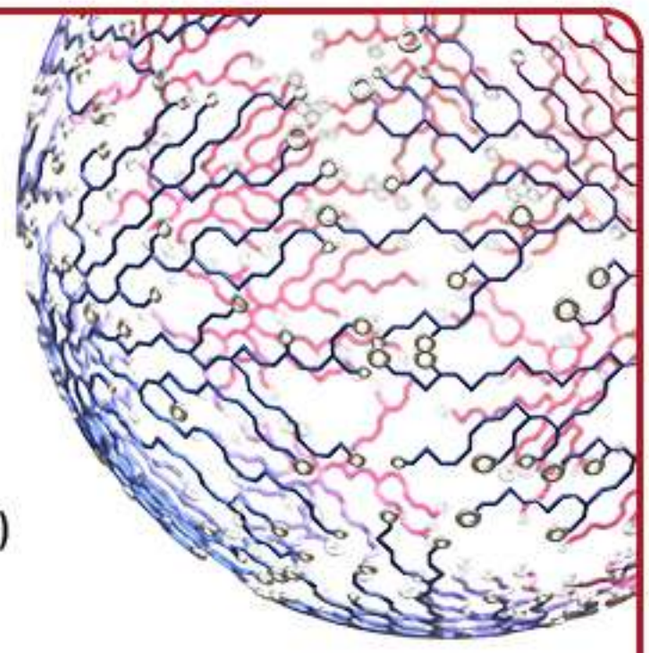

**Presenter:** Mariam Elmegaard (Gentofte University Hospital - Copenhagen, Denmark)

### Conclusion

Identification via a national health registry and digital engagement doubled the number of people initiating SGLT2 inhibitors within 6 months.

### Implications

This type of digital strategy may offer an effective new pathway for delivering evidence-based therapies.

## OBJECTIVE

To assess whether digital outreach linked to specialist evaluation could increase SGLT2 inhibitor use vs usual care in patients with HF.

## METHODS

- HF
- Identified as not treated with SGLT2 inhibitor from Danish registries

**5,996** patients randomised 1:1

**Digital strategy**

- Patient contacted via digital post system
- Offered a telephone consult with a specialist

**Usual care**

## RESULTS

- 60% of patients assigned to the digital strategy responded
  - 31% of these were eligible for SGLT2 inhibitors

| | Digital strategy | Usual care | |
|---|---|---|---|
| Initiation of SGLT2 inhibitor within 6 months | **18.6%** | 8.2% | p<0.001 |
| Hospitalisation for HF or all-cause death | 13.0% | 14.0% | p=0.276 |

# Remote Exercise SWEDEHEART

## Cluster-randomised cross-over trial on cardiac telerehabilitation

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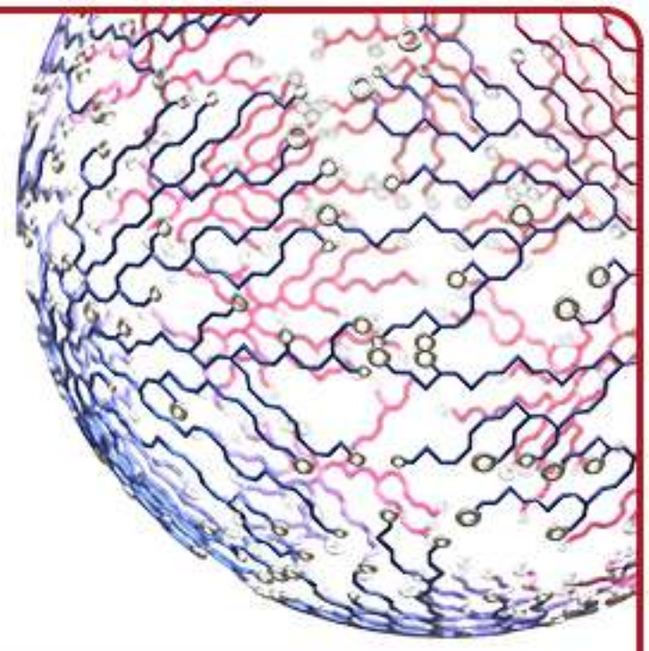

**Presenter:** Maria Bäck (Sahlgrenska University Hospital - Gothenburg, Sweden)

### Conclusion

Remotely delivered exercise-based cardiac rehabilitation (EBCR) added to centre-based EBCR resulted in a similar number of completed sessions as centre-based EBCR only.

### Implications

Remote delivery offers an additional patient-centred option but is not a replacement for centre-based EBCR.

## OBJECTIVE

To evaluate if participation in EBCR can be increased with remotely delivered sessions.

## METHODS

**3,112** patients with type 1 MI

23 Swedish centres randomised

**Intervention:** Remote/centre-based or combined EBCR

**Control:** Centre-based EBCR only

15 months

15 months

**Control:** Centre-based EBCR only

**Intervention:** Remote/centre-based or combined EBCR

## RESULTS

| | Intervention | Control |
|---|---|---|
| Proportion of patients who completed the full exercise programme | 13.8% | 13.6% |

Of all recorded exercise sessions:

~38% performed remotely

~62% performed at a centre

# VIRTUES ICD & PM

## Digital health platform for ICDs and pacemakers

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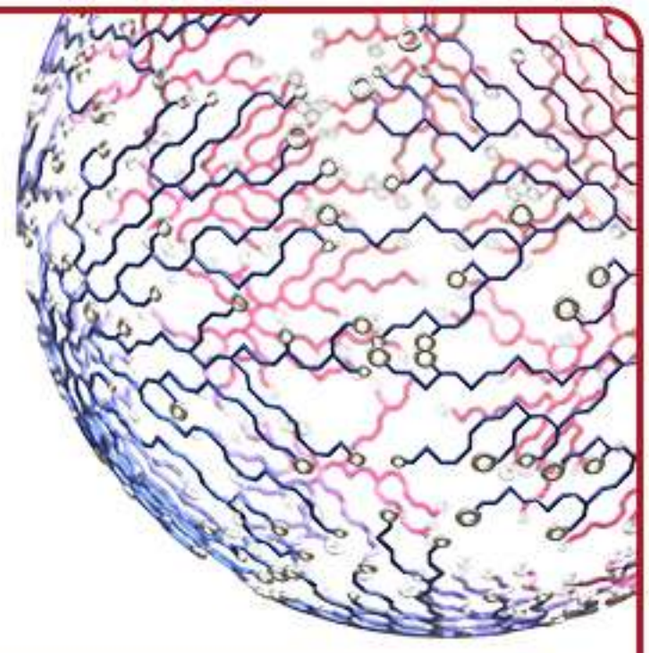

**Presenter:** Ratika Parkash (Dalhousie University - Halifax, Canada)

### Conclusion

In patients with CIEDs, virtual E-health system (VIRTUES) in combination with remote monitoring was as safe and effective as standard of care.

### Implications

Similar systems should be implemented globally to improve care and reduce costs for the healthcare system and patients.

## OBJECTIVE

To assess the safety and effectiveness of VIRTUES in addition to remote monitoring in the follow-up of patients with pacemakers or ICDs.

## METHODS

VIRTUES ICD trial:

- Transvenous or subcutaneous ICD ± CRT

VIRTUES PM trial

- Pacemaker

**1,115** patients
randomised 1:1
13 centres in Canada

- VIRTUES digital health platform
- Standard care

## RESULTS

| Over 18 months | VIRTUES | Standard care | p for noninferiority |
|---|---|---|---|
| **Primary safety outcome:** Death, stroke, CV or device-related hospitalisations | | | |
| **VIRTUES ICD** | 11.0% | 11.2% | p=0.007 |
| **VIRTUES PM** | 6.1% | 7.4% | p=0.0213 |
| **Primary efficacy outcome:** Median days from a clinically important event to a clinical decision | | | |
| **VIRTUES ICD** | Difference: +1 day | | p<0.0001 |
| **VIRTUES PM** | Difference: −3.25 days | | p<0.0001 |

# H-HeFT and meta-analysis

## Hydralazine isosorbide dinitrate (H-ISDN) in HFrEF

**Presenter:** Lars Kober and Jawad Haider Butt (Rigshospitalet - Copenhagen University Hospital - Copenhagen, Denmark)

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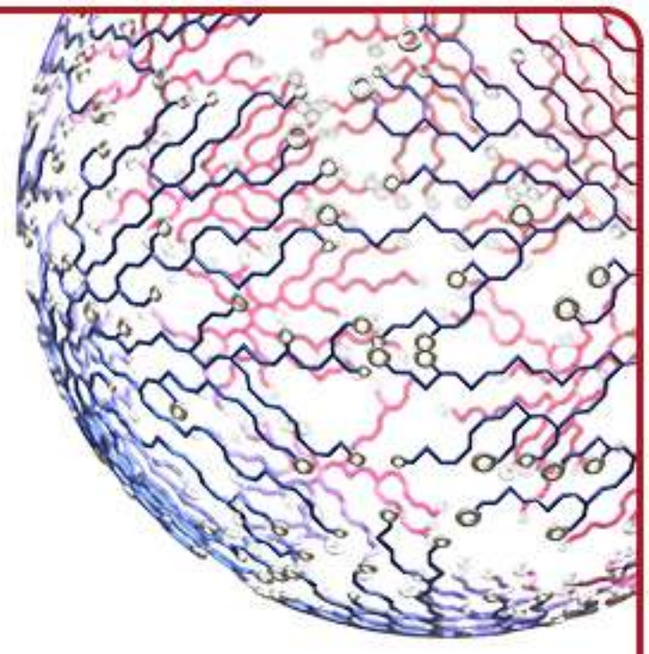

### Conclusion

There was no difference in the primary endpoint between hydralazine-isosorbide dinitrate (H-ISDN) and placebo in patients with HF.

### Implications

A high number of patients discontinued H-ISDN so no conclusions can be drawn. The tolerability of H-ISDN should be considered in clinical practice.

### OBJECTIVE

To determine whether H-ISDN improves cardiovascular outcomes in patients with heart failure.

### H-HeFT trial

- HF (NYHA II-IV)
- LVEF <40%
- Elevated NT-proBNP
- SBP >100 mmHg

**592** patients randomised 1:1

23 centres in Denmark

- **Hydralazine 37.5 mg + ISDN 20 mg (uptitrated)**
- **Placebo**

**Primary endpoint:**

Death, worsening HF, urgent outpatient visit resulting in IV or metolazone therapy for HF, heart transplantation or LVAD

Follow-up: up to 7 years

| | H-ISDN | Placebo | |
|---|---|---|---|
| **Primary endpoint** | **8.6** events/100 patient-years | **9.3** events/100 patient-years | HR 0.90; 95% CI 0.67–1.21 |
| **All-cause mortality** | **19.4%** | **24.2%** | HR 0.72; 95% CI 0.51–1.02 |

### META-ANALYSIS

- Included H-HeFT plus 2 other trials (2,101 patients)
- Substantial differences in trial design, duration of follow-up and background therapies prevent conclusions being made

# LUMINARA

## Once-daily oral relaxin agonist for treating HF

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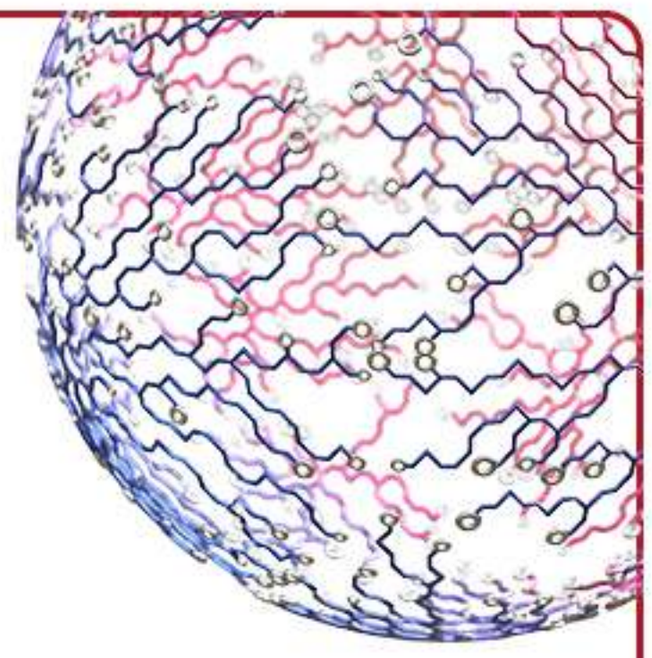

**Presenter:** James Januzzi (Massachusetts General Hospital - Harvard Medical School - Boston, USA)

### Conclusion

In this phase IIb trial, the oral relaxin agonist, AZD5462, was associated with signs of improved cardiac function and was well tolerated in patients with HF.

### Implications

Larger randomised trials with AZD5462 are now warranted, focused on outcomes.

## OBJECTIVE

To assess the efficacy and safety of AZD5462 in patients with HF.

## METHODS

- HF
- On guideline-directed medical therapies
- 235 patients with LVEF ≤35%
- 140 patients with LVEF 41–55%

**375**
patients randomised
10 countries

- **AZD5462 20 mg**
- **AZD5462 80 mg**
- **AZD5462 360 mg**
- **Placebo**

24 weeks

## RESULTS

| Change from baseline to Week 24 | | AZD5462 20 mg | p value vs placebo |
|---|---|---|---|
| LVEF ≤35% | End systolic volume index | 5.4 mL/m² ↓ | p=0.054 |
| LVEF 41–55% | Systemic vascular resistance index | 19% ↓ | p≤0.021 |

- Mild BP lowering with AZD5462, but significant hypotension not different vs placebo
- No evidence for significant volume overload with AZD5462

# Met-HeFT and meta-analysis

## Metformin and chronic HF

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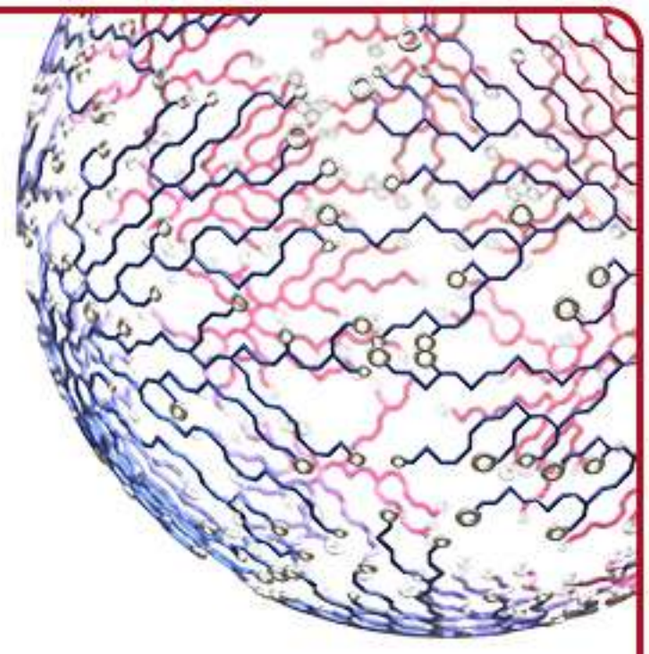

**Presenter:** Henrik Wiggers (Aarhus University Hospital - Aarhus, Denmark) and Anders Hostrup Larsen (Goedstrup Hospital - Herning, Denmark)

### Conclusion

Metformin did not significantly affect CV outcomes in patients with HF with diabetes or at risk of diabetes.

### Implications

Metformin remains beneficial for glucose lowering but there is no evidence for independent cardioprotective effects.

## OBJECTIVE

To determine whether metformin has independent cardioprotective effects in patients with HF and diabetes or at risk of diabetes.

## Met-HeFT trial

- HF
- Diabetes, prediabetes or increased risk of diabetes

**940** patients randomised 1:1

23 centres in Denmark

- Metformin
- Placebo

**Primary endpoint:**
Death, worsening HF, acute MI or stroke

Follow-up: 3.7 years

| | Metformin | Placebo | |
|---|---|---|---|
| **Primary endpoint** | 25.1% | 23.4% | HR 1.10; 95% CI 0.84–1.42 p=0.48 |

## Meta-analysis

- Included Met-HeFT plus 2 other HF trials (1,077 patients) and 4 IHD trials (1,123 patients)
- **Results were consistent with the Met-HeFT trial**

# PADN-PH-LHD

## PADN for patients with PH from heart failure

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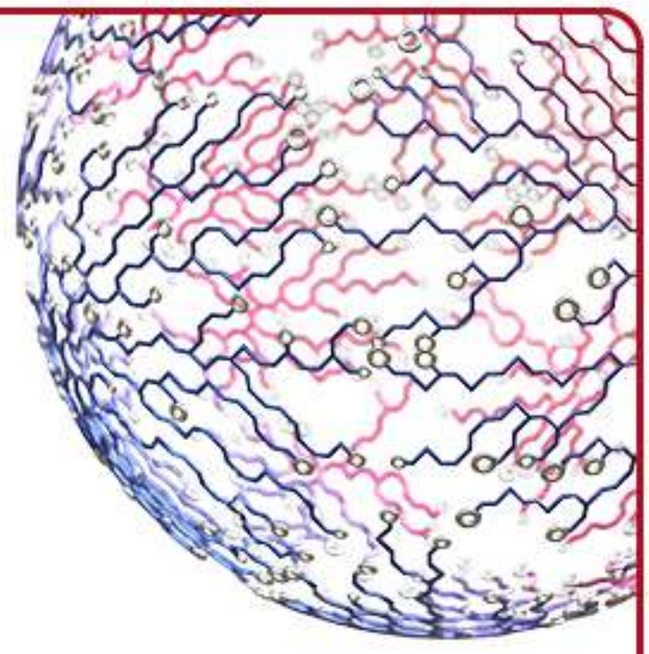

**Presenter:** Shao-Liang Chen (Nanjing First Hospital Nanjing Medical University - Nanjing, China)

### Conclusion

Pulmonary artery denervation (PADN) reduced the incidence of clinical worsening in patients with PH due to left HF receiving GDMT.

### Implications

Adding PADN to GDMT may help improve outcomes in patients with PH due to left HF.

## OBJECTIVE

To evaluate PADN for patients with HF-induced PH compared with GDMT alone.

## METHODS

- PH secondary to left HF

**264** patients randomised 1:1

25 centres in China

**PADN plus GDMT**

**GDMT**

## RESULTS

### Primary endpoint: Clinical worsening

All-cause mortality, heart or lung transplantation, HF hospitalisation, outpatient worsening HF requiring IV medication, or a ≥10% or >30-m absolute decline in 6MWD from baseline

Median follow-up: 338 days

**PADN + GDMT: 25.7%**

**GDMT: 51.5%**

**51% reduction**

HR 0.49
95% CI 0.30–0.82
p=0.0059

# TIME-HF

## Team-based collaborative care model in HF

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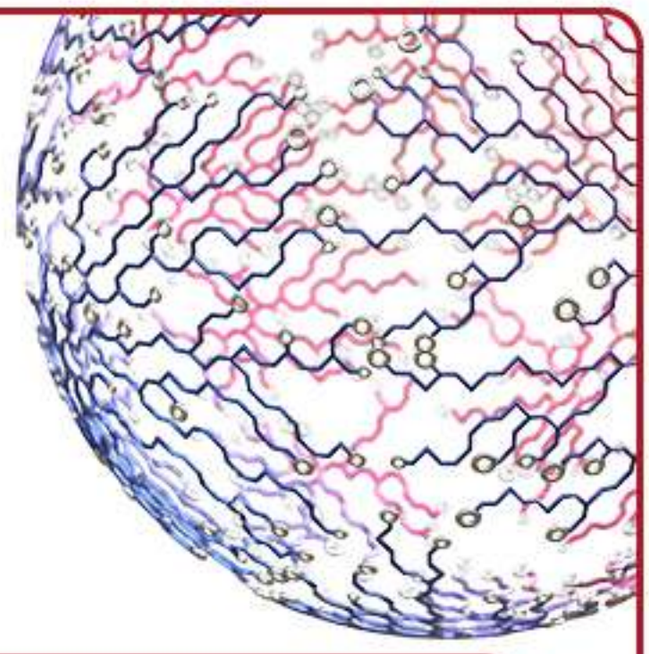

**Presenter:** Panniyammakal Jeemon (SCTIMST - Thiruvananthapuram, India)

### Conclusion

A nurse-led mobile health intervention improved days alive and out of hospital at 2 years in patients with HFrEF vs usual care.

### Implications

Structured, nurse-coordinated, technology-enabled interventions could improve routine HF management across a broad range of settings where guideline-directed medical therapy (GDMT) uptake is suboptimal.

## OBJECTIVE

To determine whether a nurse-led, mobile health-based intervention could improve HF outcomes vs usual care.

## METHODS

**1,507**
adults with HFrEF

22 centres in India
Randomised 1:1

- **Nurse-led mobile health intervention**
- **Usual care**

## RESULTS

| | Nurse-led intervention | Usual care | |
|---|---|---|---|
| Adherence to 4 GDMT at 2 years | **37.3%** | 22.1% | |
| Surviving and out of hospital at 2 years | **84.0%** | 79.4% | p<0.001 |
| Deaths at 2 years | ↓ 22.0% vs usual care | | p=0.028 |

# ACASA-TAVI

## Antithrombotic therapy after TAVI

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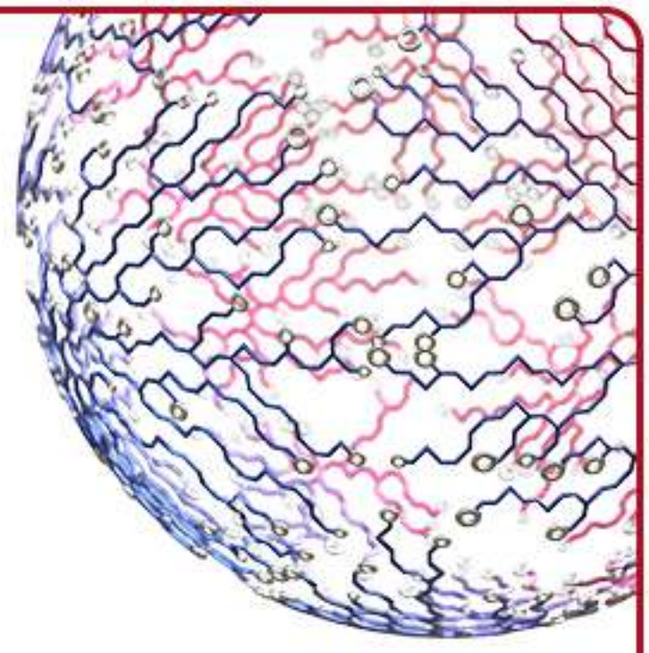

**Presenter:** Øyvind H Lie (Oslo University Hospital Rikshospitalet - Oslo, Norway)

### Conclusion

After TAVI, substantial reductions in subclinical leaflet thrombosis were observed with NOAC monotherapy vs ASA monotherapy, without compromising safety.

### Implications

NOAC monotherapy could represent an effective and safe antithrombotic approach after TAVI.

## OBJECTIVE

To compare NOAC monotherapy and ASA monotherapy for subclinical leaflet thrombosis and safety in patients after TAVI without an indication for anticoagulation.

## METHODS

- Successful TAVI
- Aged 65–80 years

**360**
patients
randomised 1:1
3 centres in Norway

**NOAC monotherapy**
Any of apixaban, edoxaban or rivaroxaban

**ASA monotherapy**
75 mg daily

## RESULTS

| At 12 months | NOAC monotherapy | ASA monotherapy | |
|---|---|---|---|
| **Primary efficacy endpoint**<br>Hypo-attenuated leaflet thickening | 17.2% ↓ | 32.6% | RR 0.55<br>95% CI 0.37–0.82<br>p=0.004 |
| **Primary safety endpoint**<br>VARC-3 bleeding events, thromboembolic events and all-cause death | 7.5% ↔ | 10.6% | –3.3 %<br>p for noninferiority <0.001 |

# NOTION-4

## Subclinical leaflet thrombosis after TAVI

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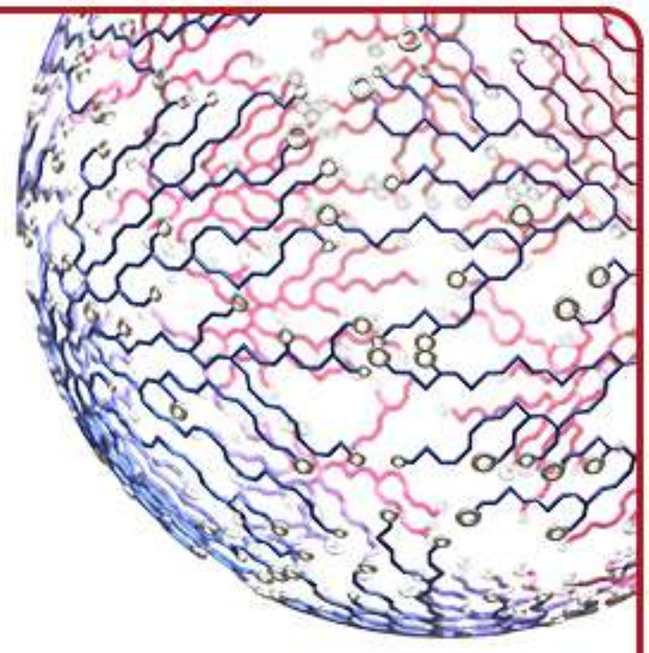


**Presenter:** Troels Hojsgaard Jorgensen (Rigshospitalet - Copenhagen University Hospital - Denmark)

### Conclusion

After TAVI, a 3-month DOAC regimen reduced subclinical valve thrombosis at 3 months but not at 12 months vs SAPT, and was associated with an increased risk of adverse outcomes.

### Implications

The results do not support the use of this DOAC regimen in patients after TAVI without an indication for anticoagulation.

## OBJECTIVE

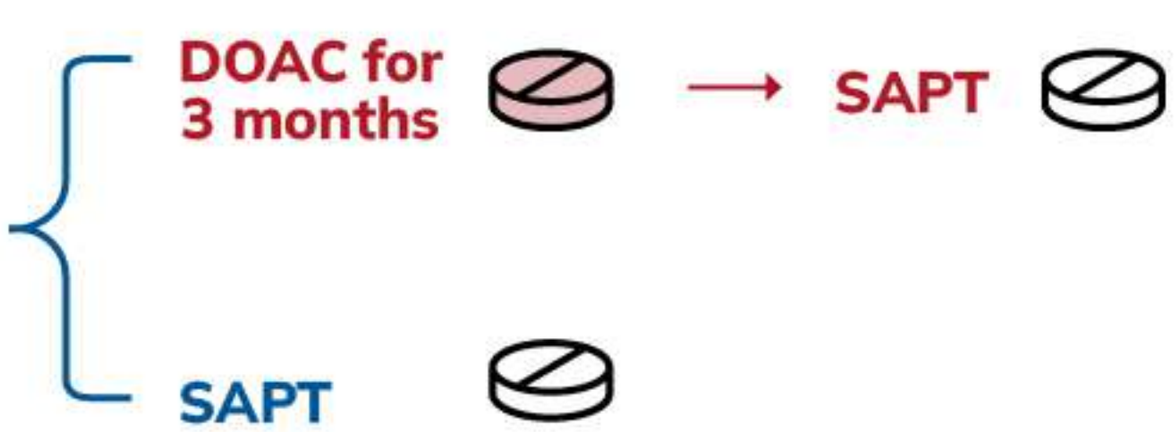
To compare antithrombotic strategies for the prevention of hypo-attenuated leaflet thickening in patients after TAVI without an indication for anticoagulation.

## METHODS

- Successful TAVI
- No indication for OAC therapy

**352** patients randomised 1:1

2 centres in Denmark




## RESULTS

| | DOAC then SAPT | SAPT | |
|---|---|---|---|
| Hypo-attenuated leaflet thickening at 3 months | 12.1% | 31.8% | p<0.001 |
| **Primary endpoint** Hypo-attenuated leaflet thickening at 12 months | 28.3% | 32.2% | p=0.54 |
| All-cause mortality, stroke or major/life-threatening bleeding at 12 months | 8.8% | 2.3% | p=0.008 |

# POPular ACE TAVI

## Routine or selective protamine administration after TAVI

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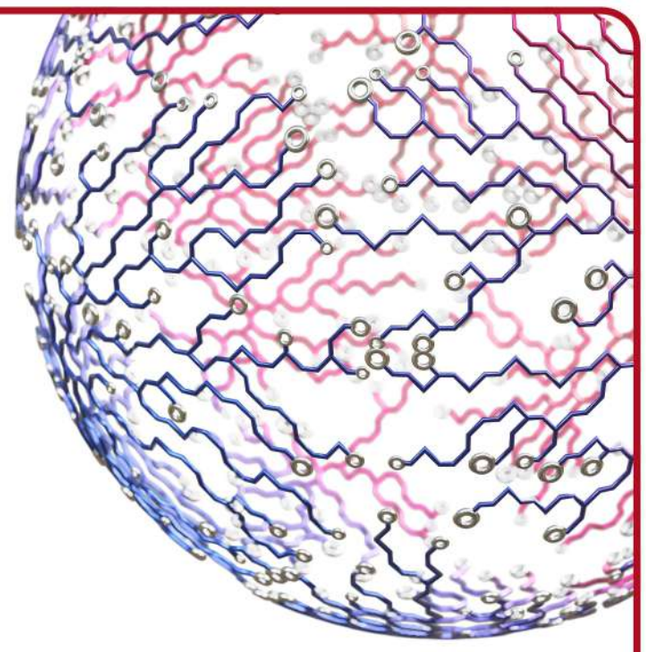

**Presenter:** Christiaan Overduin (St Antonius Hospital - Nieuwegein, Netherlands)

### Conclusion

Routine protamine after TAVI reduced all-cause death or clinically relevant bleeding at 30 days vs selective protamine.

### Implications

Data support routine protamine after TAVI to reduce minor bleeding, but this should be balanced against a small risk of anaphylaxis.

## OBJECTIVE

To assess the safety and efficacy of routine vs selective protamine administration before large-bore arterial sheath removal after transfemoral TAVI.

## METHODS

- Undergoing TAVI
- No recent PCI

**966** patients randomised 1:1

6 centres in Belgium and Netherlands

**Routine protamine**

**Selective protamine**

Follow-up: 30 days

## RESULTS

| | Routine vs Selective | |
|---|---|---|
| **Primary endpoint** All-cause mortality or clinically relevant bleeding | Risk difference: **–10.9%** 95% CI –17.0 to –4.8; p<0.001 | ↓ |
| Bleeding type 1 | Risk difference: **–10.9%** 95% CI –16.8 to –5.1 | ↓ |
| Anaphylaxis | Risk difference: **1.3%** 95% CI 0.2 to 3.0; p=0.01 | ↑ |

# TAVI PCI

## Timing of PCI/TAVI in patients planned for both

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**Presenter:** Barbara Elisabeth Stähli
(University Hospital Zurich - Zurich, Switzerland)

### Conclusion

TAVI-then-PCI was noninferior to PCI-then-TAVI after 1 year, with no safety concerns in patients with both severe AS and CAD.

### Implications

An individualised approach to procedure timings may be adopted.

## OBJECTIVE

To test the hypothesis that TAVI-then-PCI is noninferior to PCI-then-TAVI in patients with severe AS and concomitant CAD.

## METHODS

- Severe AS and CAD
- Eligible for TAVI and PCI

**986**
randomised 1:1
48 centres in Europe


## RESULTS

| | TAVI→PCI | PCI→TAVI | |
|---|---|---|---|
| **Primary endpoint at 1 year**<br>All-cause death, nonfatal MI, ischaemia-driven revascularisation, valve-, procedure- or HF-related rehospitalisation or life-threatening, disabling or major bleeding | 22.2% | 24.2% | p<0.001 for noninferiority |

# TRIC-I-HF

## Tricuspid intervention in heart failure

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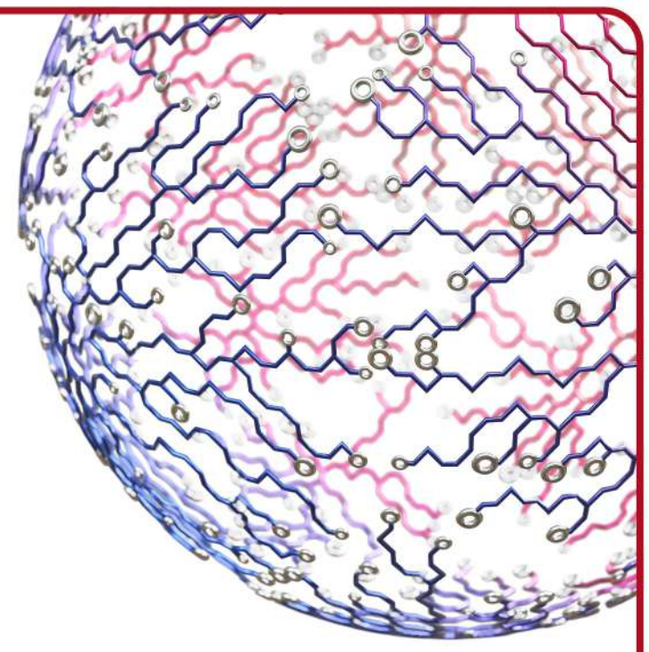

**Presenter:** Joerg Hausleiter (Ludwig Maximilians University - Munich, Germany)

### Conclusion

Transcatheter tricuspid valve repair (TTVR) significantly improved clinical outcomes in high-risk patients with severe tricuspid regurgitation (TR).

### Implications

These results establish TTVR as a possible effective disease-modifying therapy.

## OBJECTIVE

To assess whether TTVR plus medical therapy improves symptoms and outcomes in high-risk patients with severe TR compared with medical therapy alone.

## METHODS

- Severe TR despite optimal medical therapy
- **High risk:**
  HF hospitalisation within previous 1 y or cardio-renal syndrome or cardio-hepatic syndrome

**360**
patients randomised 2:1

29 high-volume centres in Germany

**TTVR**
**(any CE-marked device)**
plus medical therapy

Medical therapy only

## RESULTS

| Hierarchical analysis of primary endpoints | TTVR plus medical therapy | Medical therapy only |
|---|---|---|
| **First:** All-cause mortality, HF hospitalisation and lack of QoL improvement at 1 y | Win ratio 2.42<br>95% CI 1.76–3.33; p<0.001 | |
| **Second:** All-cause mortality or HF hospitalisation at 3 y | HR 0.40<br>95% CI 0.29–0.55; p<0.001 | |

# AFFIRMO

## AF integrated approach in Frail, multimoRbid and polyMedicated Older people

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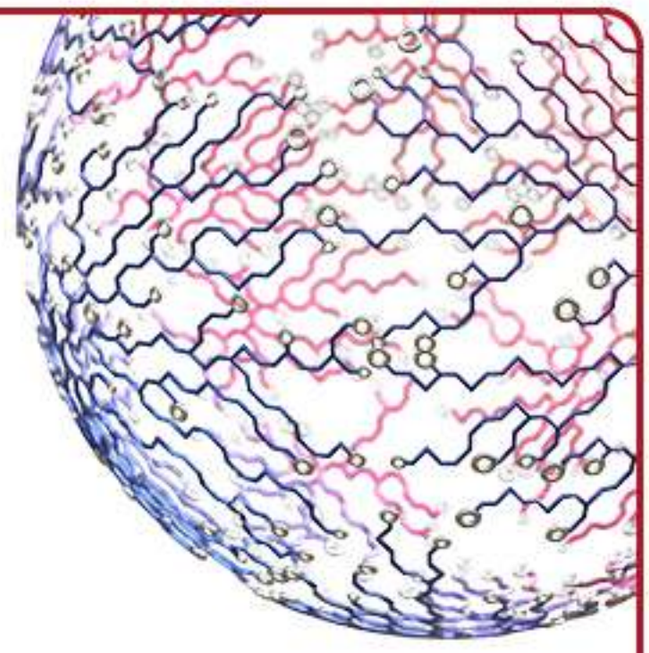


**Presenter:** Gregory YH Lip (University of Liverpool - Liverpool, UK)

### Conclusion

A mobile-health integrated care approach based on the ABC pathway (iABC) plus Comprehensive Geriatric Assessment (CGA) did not reduce unplanned hospitalisations vs usual care.

### Implications

The iABC system was designed to improve guideline adherence but there was high baseline guideline adherence and low event rates, with low use of the mobile app and limited efficacy of CGA in this well-preserved population.

## OBJECTIVE

To evaluate the efficacy of a mobile-health intervention adapting the ABC pathway and combining CGA in older patients with AF and comorbidities.

## METHODS

- Aged ≥65 years
- Any AF type
- At least 1 comorbidity

**1,260**
patients
Cluster randomised trial
6 European centres

**iABC + CGA**
App
Clinician dashboard

**Usual care**

## RESULTS

- Guideline adherence was very high at baseline in both arms

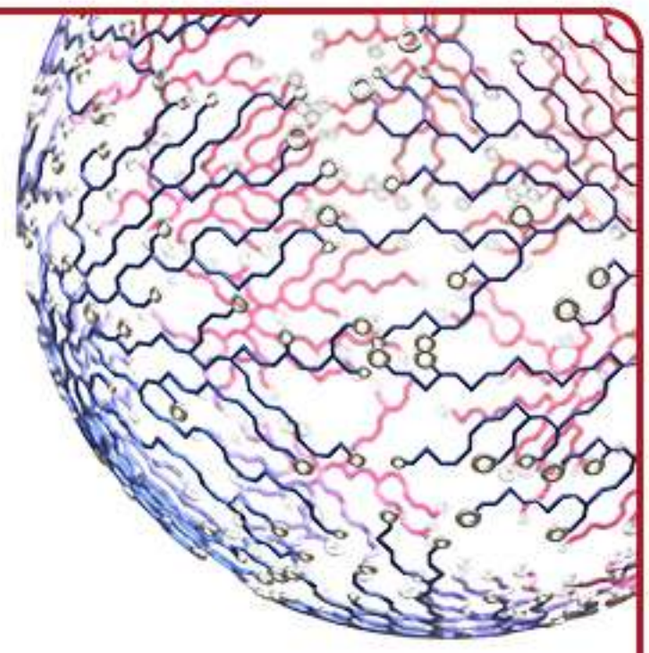
| | iABC | Usual care | |
|---|---|---|---|
| **Primary endpoint**<br>All-cause unplanned hospitalisations at 1 year | 17.1% | 18.2% | OR 0.95<br>95% CI 0.61–1.49<br>p=0.84 |

# IDEAL-AF

## Individualised low-voltage ablation in persistent AF

ESC European Society of Cardiology

#ESCCongress



**Presenter:** Astrid Paul Nordin (Karolinska Institute - Stockholm, Sweden)

### Conclusion

In patients with persistent AF and significant low-voltage zones (LVZ), LVZ ablation with PVI improved rhythm outcomes and QoL vs PVI alone with no safety concerns.

### Implications

Tailored treatment with LVZ ablation improved the treatment of persistent AF.

## OBJECTIVE

To evaluate whether ablation of LVZs in addition to PVI improves rhythm outcomes compared with PVI alone in patients with persistent AF and significant LVZ substrate.

## METHODS

- Persistent AF
- ≥1 LVZ ≥3.0 $cm^2$
- First-time catheter ablation

**209**
patients randomised 1:1
5 centres in Sweden

**LVZ ablation + PVI**

**PVI**

## RESULTS

| | LVZ ablation + PVI | PVI alone |
|---|---|---|
| **Primary endpoint**<br>**Freedom** from documented atrial arrhythmia lasting >30 sec without anti-arrhythmic drugs at 1 y | 67.6% | 37.4% |
| | OR 3.50<br>95% CI 1.98–6.20; p<0.001 | |

**LVZ ablation + PVI** — **Improved QoL by AFEQT** ✓ — **Safety** ✓

# NEXAF

## Long-term exercise in patients with non-permanent AF

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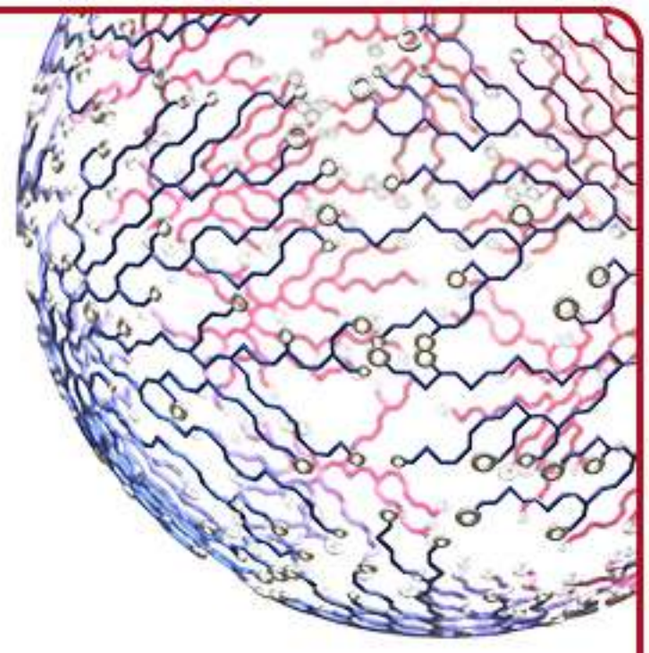

**Presenter:** Bjarne Nes (Norwegian University of Science and Technology - Trondheim, Norway)

### Conclusion

A 12-month exercise programme reduced the total AF burden and improved cardiopulmonary fitness but did not increase AF-specific QoL vs usual care.

### Implications

This hybrid model was feasible and may enable wider use of exercise-enabled rehabilitation.

## OBJECTIVE

To evaluate the effect of a long-term supervised and eHealth-based exercise intervention on AF burden and AF-specific QoL.

## METHODS

- Non-permanent AF
- Physical activity level less than recommended

**295** patients randomised 1:1

3 centres in Norway

**Exercise** → **Home-based eHealth**
Supervised sessions for 4 weeks

**Usual care**
No structured or supervised exercise

## RESULTS

**Exercise vs usual care at 12 months**

**Primary endpoints**

**Time in AF**

**3.9%** with exercise

**7.1%** with usual care

p=0.016

**Cardiopulmonary fitness** ↑

**Overall AFEQT score**

**+5.6** with exercise

**+4.4** with usual care

p=0.43

**Hospitalisations** ↓

# PVI-SHAM-AF

## Pulmonary vein isolation vs sham in AF

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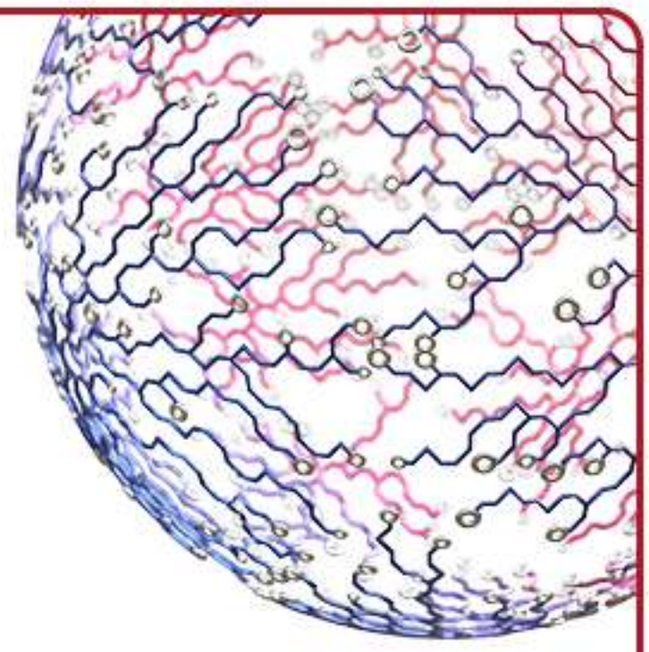
#ESCCongress

**Presenter:** Rolf Wachter (University of Leipzig Medical Centre - Leipzig, Germany)



### Conclusion

Catheter ablation did not improve AF-related quality of life compared with a sham intervention, despite reducing AF recurrence.

### Implications

These data should be discussed with patients when catheter ablation is being considered.

## OBJECTIVE

To investigate improvements in AF-related quality of life with catheter ablation compared with a sham procedure.

## METHODS

- Symptomatic paroxysmal or persistent AF

**262** patients randomised 2:1

9 sites in Germany and Poland

**Catheter ablation**

**Sham procedure**

**Primary endpoint**

Change in AF Effect on the Quality of Life (AFEQT) questionnaire from baseline to 6 months

## RESULTS

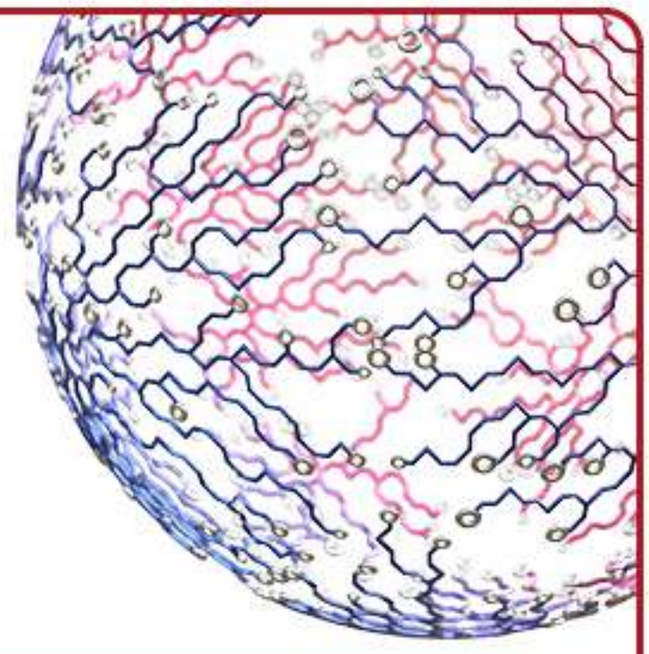
| | Catheter ablation | Sham procedure | |
|---|---|---|---|
| AFEQT summary score at baseline and 6 months | 61.3 → 81.1 | 59.2 → 74.9 | p=0.36 |
| Freedom from AF at 6 months | 73% | 52% | |

# Blood pressure-lowering treatment across the spectrum of CV risk

**Presenter:** Kazem Rahimi (University of Oxford - Oxford, UK)

ESC European Society of Cardiology

#ESCCongress



## Conclusion

The relative benefits of pharmacological BP lowering were seen regardless of CV risk. Absolute benefits were larger at higher baseline risk.

## Implications

Risk-guided management could prevent CV events missed under conventional strategies while avoiding unnecessary treatment in those least likely to benefit.

## OBJECTIVE

To examine whether the benefits of BP lowering extend across the spectrum of CV risk.

## METHODS

- Meta-analysis
- Trials of antihypertensive treatment vs comparator

**51**
trials identified

→ **357,440 participants** classified into 10 categories (from <4% to >27%) by predicted 5-year CV risk at randomisation →

**Primary outcome**
**Major CVD**
(nonfatal or fatal stroke, nonfatal or fatal IHD, or HF resulting in death or hospitalisation)

Median follow-up:
4.2 years

## RESULTS

- **Major CVD: HR 0.90 (95% CI 0.88–0.92) per 5 mmHg reduction in SBP**
- **Homogeneous across predicted-risk categories**

p for interaction >0.99

- **Absolute benefits increased progressively with baseline predicted risk**

Lowest risk decile (<4%): absolute risk reduction 0.4 percentage points
Highest risk decile (>27%): absolute risk reduction 2.6 percentage points

p for trend <0.001

# CRHCP

## Long-term blood pressure control and dementia risk

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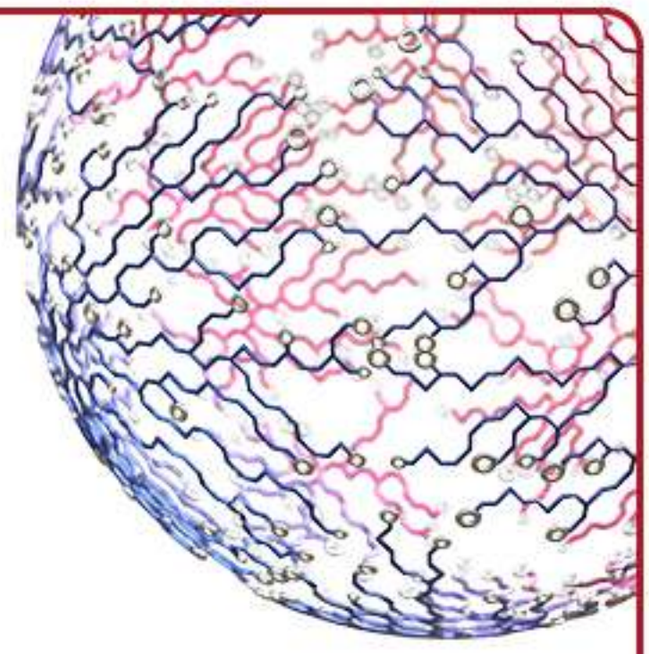


**Presenter:** Shanshan Zhong (The First Affiliated Hospital of China Medical University - Shenyang, China)

### Conclusion

A community-based intervention delivered by non-physician HCPs resulted in substantial reductions in blood pressure and also in dementia.

### Implications

Wider use of this scalable intervention globally may help to reduce the increasing burden of dementia.

## OBJECTIVE

To assess whether intensive BP lowering reduces the incidence of dementia.

## METHODS

326 villages in rural China randomised

**33,995** adults

- Aged ≥40 years
- Untreated ≥140/90 mmHg (≥130/80 mmHg if treated or high risk)

**Community intervention**

Trained non-physician HCPs adjusted BP medication

Active trial: 4 y → Observation: 3 y

**Usual care**

## RESULTS

| At the end of 7-y period | Community intervention | Usual care | |
|---|---|---|---|
| **SBP reduction** | 17.6 mmHg | 2.4 mmHg | |
| **Dementia** | 8.85% | 10.55% | p<0.001 |

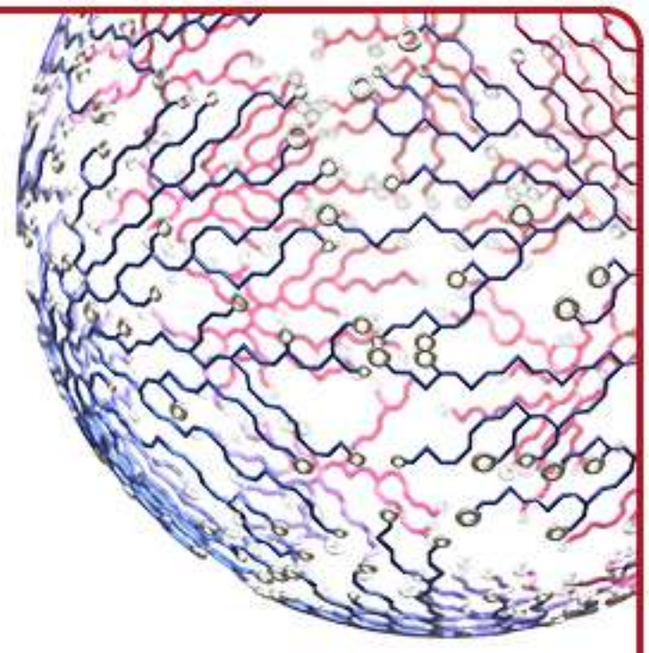
# ECLIPSE-CKD

## Salt substitute in CKD

**Presenter:** Dong Shui (Harbin, China)

ESC European Society of Cardiology

#ESCCongress



### Conclusion

In adults with hypertension and CKD, salt substitution lowered BP and modestly increased serum potassium over 3 months, with no episodes of hyperkalaemia.

### Implications

Salt substitution may provide a scalable adjunct to BP management. Further trials are required to establish long-term effects on CV and kidney outcomes, and safety.

## OBJECTIVE

To assess the efficacy and safety of salt substitutes in patients with CKD.

## METHODS

- Hypertension
- eGFR 45–89 mL/min/1.73 m²

**640** patients randomised 1:1

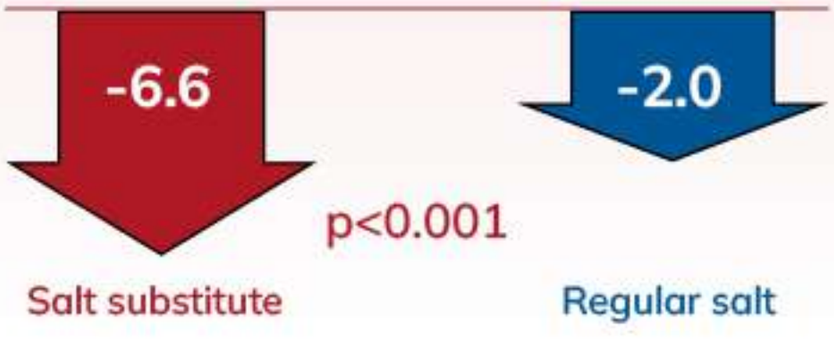
7 centres in China

- **Salt substitute**: 75% sodium chloride and 25% potassium chloride
- **Regular salt**: 100% sodium chloride

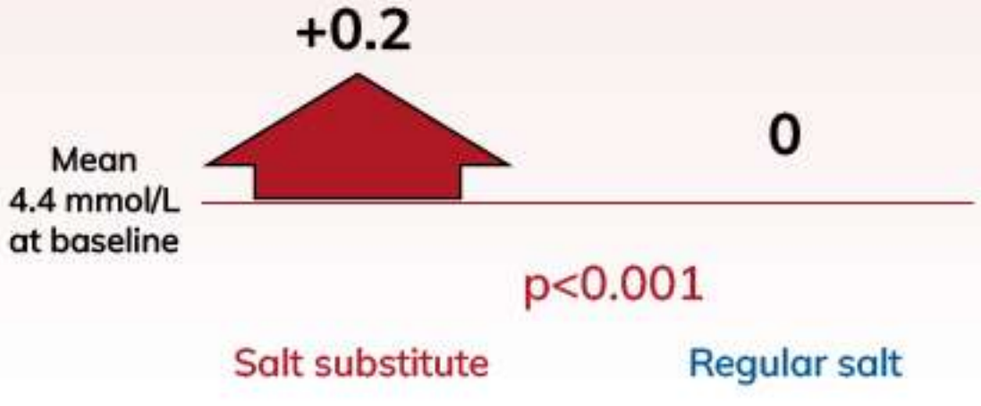
## RESULTS

**Primary endpoint**

Change in SBP (mmHg) from baseline to month 3




Change in serum potassium (mmol/L) from baseline to month 3




No episodes of hyperkalaemia were observed

# SHASTA-3/4

## Plozasiran in severe hypertriglyceridaemia

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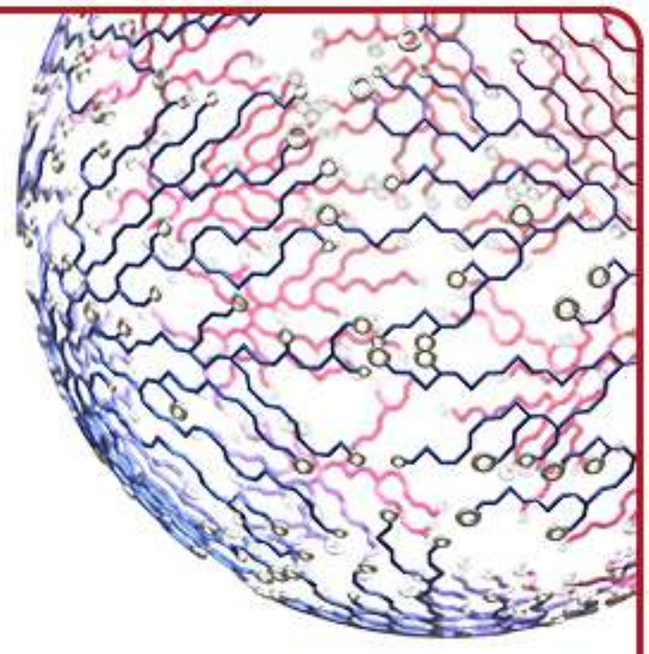

**Presenter:** Gerald Watts (University of Western Australia - Perth, Australia)

### Conclusion

Plozasiran treatment resulted in substantial reductions in triglyceride levels in patients with severe hypertriglyceridaemia after 1 year.

### Implications

Plozasiran may represent a promising therapy for patients with limited current treatment options.

## OBJECTIVE

To assess plozasiran in patients with severe hypertriglyceridaemia.

## METHODS

- Severe hypertriglyceridaemia (TG ≥ 500 mg/dL)

**757**
patients randomised 2:1
24 countries

**Plozasiran 25 mg SC every 3 months**

**Placebo SC every 3 months**

## RESULTS

| | Plozasiran | Placebo |
|---|---|---|
| **Primary endpoint**<br>Median triglyceride reductions | 79–81% | ~27% |
| Acute pancreatitis events | Risk ratio 0.22<br>95% CI 0.07–0.67; p=0.008 | |