I was very appreciative of the NZHPA for assistance in attending the Cardiac Society of Australia and New Zealand (CSANZ) annual conference in Perth July/August 2024 which also included a Cardiometabolic symposium on the first day. This was a record-breaking conference for CSANZ, with the biggest attendance numbers and abstracts submitted in their history. There were over 40 expert international speakers including cardiologists, multidisciplinary team members and cardiac researchers. It was also the first CSANZ conference to hold a specific pharmacist roundtable meeting of cardiology pharmacists from around Australasia, which we have Adam Livori and Joh Lim to thank for their efforts in making this happen. There were around 17 pharmacists at the conference, and it was great to meet + share initiatives at the roundtable followed by 3 more days of informal discussions, sharing ideas and challenges that we face in how we work as pharmacists in cardiology across Australia and New Zealand.

I personally gained a lot of new knowledge from attendance at the conference. Some of the highlights I have included information on below.

Management of Atrial Fibrillation.

Rates of hospital admissions for AF increasing much faster than ACS and heart failure.

Discussion on CHADs VASC scoring limitations – trials underway looking at new improved risk scores in AF. How the modified CHADs VASC can be useful in some population groups.

New pillar of treatment for all AF patients remember risk factor reduction for all !!

HEAD-2 TOES

Table 3 | The HEAD-2-TOES scheme: modifiable risk factor targets to prevent AF

Acronym	Risk factor	Primary prevention targets	Secondary prevention targets
H	Heart failure (with reduced ejection fraction)	ACE inhibitor or ARB, β-blocker, MRA, SGLT2 inhibitor	ACE inhibitor or ARB, MRA
E	Exercise (physical inactivity)	≥150 min per week MVPA	≥200 min/per week MVPA
A	Arterial hypertension	BP <130/80 mmHg	BP <130/80 mmHg (rest) and <200/100 mmHg (exercise)
D2	Diabetes mellitus type 2	HbA1c <6.5%	Dietary changes and HbA1c <6.5%
T	Tobacco smoking	Complete cessation	Complete cessation
O	Obesity	BMI ≤25 kg/m^2	10% weight reduction; BMI ≤27 kg/m^2
E	Ethanol consumption	≤1 standard drink[a] per day	≤3 standard drinks[a] per week
S	Sleep apnoea	AHI <15	AHI <15 without CPAP; CPAP for AHI ≥30 or AHI ≥20 with hypertension

ACE, angiotensin-converting enzyme; AF, atrial fibrillation; AHI, apnoea–hypopnoea index; ARB, angiotensin receptor blocker; BP, blood pressure; CPAP, continuous positive airway pressure; HbA1c, glycated haemoglobin; MRA, mineralocorticoid receptor antagonist; MVPA, moderate-to-vigorous physical activity; SGLT2, sodium–glucose cotransporter 2. [a]One standard drink contains 12 g of alcohol (1.5 units).

Elliott, Adrian D., et al. "Epidemiology and modifiable risk factors for atrial fibrillation." Nature Reviews Cardiology 20.6 (2023): 404-417.

Cardiometabolic

This topic had a dedicated symposium on day 1, but recurrent related talks through the conference around hypertension, obesity, dyslipidaemia, AF and diabetes and how to manage these often very co-morbid patients who may be interacting with multiple specialties.

There was a focus on the management of HFpEF which for so many years has not had the same medication evidence base for treatment as HFrEF, but with more trials now showing benefits with SGLT2 inhibitors and GLP 1 agonists a lot more information was coming through on the importance of early recognition of this complex syndrome.

There are also some exciting new drug targets for hypertension in the pipeline including dual endothelin receptor antagonists, aldosterone synthase inhibitors and SiRNA working on RASS inhibition with prolonged effects over 6 months.

Perioperative cardiac complications (AF and peri op MI)

Another new acronym to remember – MINS Myocardial injury after non-cardiac surgery. Discussed the use of post op troponins after non-cardiac surgery to monitor for MINs which can often be masked symptomatically due to analgesia given in the perioperative period. I do wonder how we could target this testing to highest risk patients as it wouldn't be cost effective as a blanket measure.

Post op AF in non-cardiac patients – still more questions than answer in terms of whether to anticoagulated and for how long. Await results of ASPIRE AF RCT…

Of interest in the Cardiac Surgery space

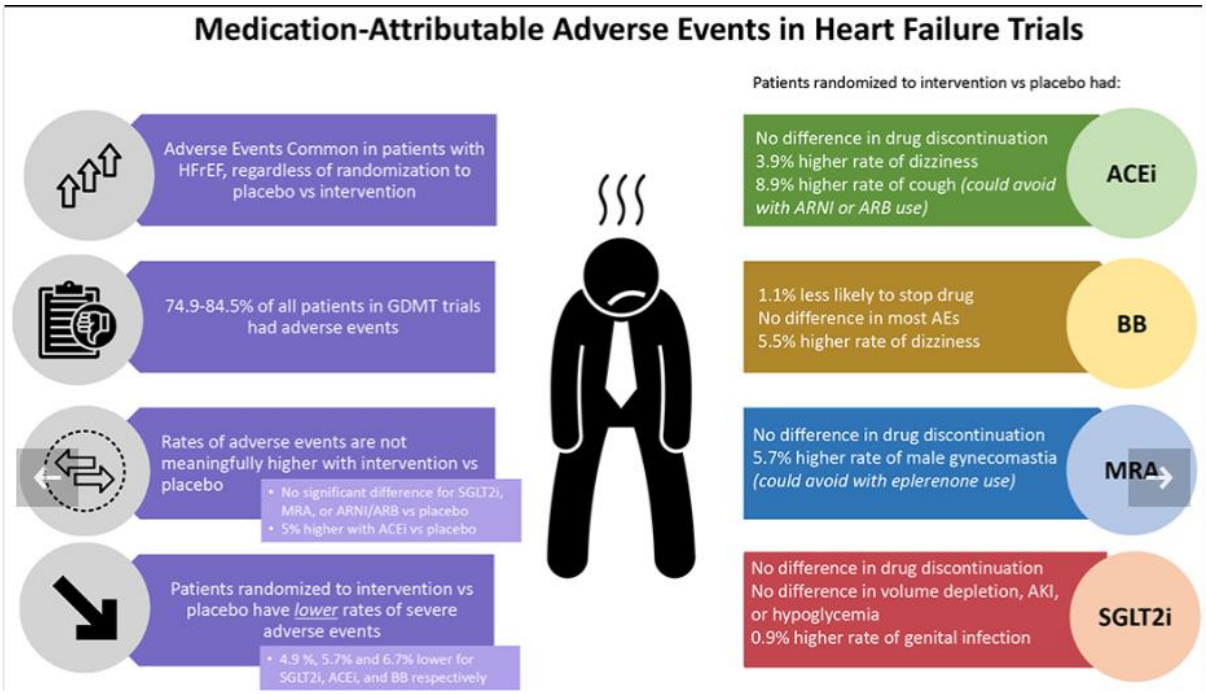
Pulmonary endarterectomy for CTEPH as a treatment option for management of PAH – unsure if any centres in NZ are doing this but it was discussed by a Sydney cardio thoracic surgeon.

Ross procedure coming back into vogue as an option for valve surgery in adults.

Sternal sparing Aortic valve replacement with RAT – Right anterior thoracotomy.

Heart failure

Many of us had seen the Nocebo effect with regards to statins, but it was also discussed in terms of the management of HFrEF as well. We now have the 4 pillars of guideline directed medical therapy in HFrEF, but registry data is still showing that patients are frequently not on all treatments or are not getting doses titrated sufficiently. The below table suggest that a lot of HF medication related ADRs could be related to the condition rather than the medications themselves.



Harrington, J., Fonarow, G. C., Khan, M. S., Hernandez, A., Anker, S., Böhm, M., ... & Butler, J. (2023). Medication-attributable adverse events in heart failure trials. Heart Failure, 11(4), 425-436.

I would highly recommend the CSANZ conference or annual scientific meetings (ASM) for any pharmacist with an interest in cardiology in either secondary or primary care. The 2025 events are in Rotorua (ASM) in May and the conference in Brisbane in August. Many thanks again to NZHPA for supporting my attendance.

Some of the pharmacists in Attendance from NZ and Australia.