

**NHS GG&C Heart MCN Key Messages**

**June 2021**

1. **Long COVID**

Referral numbers for patients with suspected ‘long COVID’ and symptoms of palpitation and dyspnoea are increasing. In general, initial concerns about myocarditis and LV damage have been overstated and we have not seen any patient with this as part of a ‘long COVID’ presentation. We were involved in the national guidance for cardiac symptoms in these patients (link below) but basically it involves some basic test to make sure we are not missing any non-COVID heart disease.

<https://www.sign.ac.uk/media/1840/implementation-support-note-managing-the-long-term-effects-of-covid-19-5-may-2021-corrected.pdf>

1. **CT coronary artery calcification (CAC)**

CAC is now being reported by radiologists on routine CT scans which include the thorax and we have been asked to provide some guidance on what to do when such a report is received.

CAC is an established biomarker for the burden of atherosclerosis with an increase in CAC associated with increased risk of cardiovascular events in symptomatic and asymptomatic patients. The presence of CAC in an asymptomatic patient should therefore prompt the prescription of statin and aspirin. A high burden of CAC may be present in patients we’ve classified as “low risk” by the ASSIGN scoring systems and conversely absent in patients classified at “high risk”. Combining CAC with traditional risk factors can therefore improve coronary artery disease risk stratification and appropriately target statin therapy.

Significant CAC may be present in the absence of any flow-limiting coronary artery stenoses but it is **not** a method to identify the severity of coronary artery stenosis. Just to makes things more complicated, coronary artery disease may be present in the absence of CAC. Patients with CAC who have symptoms suggestive of angina will require anti-anginal therapy in addition to statin and aspirin, along with referral to cardiology.

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