

Table 3. End-of-Markov Model results for Inclisiran (25 years)

Outcomes	Inclisiran + standard therapy	Standard Therapy	Difference
Total Pooled MACE	79,107	105,197	(26,090)
Total DALY's saved	186,608	180,785	5,822
Total Cost	\$3,434,720,212	\$2,927,169,254	\$507,550,958 or \$20,302,038/ year
ICER without CVD-MOC	-	-	\$87,171
Estimated ICER with CVD-MOC	-	-	\$81,091

Method: A Markov cohort state-transition model was cycled annually over 25 years for Aboriginal and Torres Strait Islander Australians with CVD and hypercholesterolaemia to receive either Inclisiran and Statin, or statin alone (**Figure 1**). Transition probabilities, utilities, costs and discounting were literature-derived. The ICER was our primary outcome. Pooled MACE and disability-adjusted life years (DALY's) prevented were secondary outcomes. Sensitivity analysis for various scenarios were performed.

Results: In the estimated 12,180 Aboriginal and Torres Strait Islander Australians with CVD and hypercholesterolaemia (**Table 2**), first-line Inclisiran prevented an additional 26,090 MACE and 5,822 DALYS. It cost the Australian government an additional \$507,550,958, or \$20,302,038/year, representing only 0.14% of annual CVD expenditure. The ICER was \$87,171/QALY, which improved to \$81,091/DALY when used with a secondary prevention CVD-MOC (**Table 3**).

Conclusions: For Aboriginal and Torres Strait Islander Australians with CVD and hypercholesterolaemia, funding Inclisiran first-line with statin, especially when incorporated into a CVD-MOC, may be cost-effective to the Australian healthcare system whilst crucially closing-the-gap in health-care outcomes.

<https://doi.org/10.1016/j.hlc.2025.06.025>

010

Clinical Implications of Isolated Right Precordial T Wave Inversion in Screening Electrocardiograms of Female Athletes



J. Orchard^{1,*}, J. Drezner², H. Raju³, R. Puranik¹, B. Gray¹, M. Brosnan⁴, R. Doughty⁵, B. Hamilton⁶, T. Driscoll¹, A. Davis¹, E. Buckthorpe⁷, S. Eggleton⁸, A. Baggish⁹, A. La Gerche^{4,10}, J. Orchard¹

¹The University of Sydney, Sydney, NSW, Australia

²University of Washington, Center for Sports Cardiology, Seattle, Washington, USA

³Macquarie University, Sydney, NSW, Australia

⁴St Vincent's Hospital, Melbourne, VIC, Australia

⁵University of Auckland, Auckland, New Zealand

⁶Sports Performance Research Institute New Zealand (SPRINZ), Auckland University of Technology, Auckland, New Zealand

⁷Australasian College of Sport and Exercise Physicians, Melbourne, VIC, Australia

⁸University of New South Wales, Sydney, NSW, Australia

⁹Division of Cardiology (CHUV) and Institute of Sport Sciences (ISSUL), University of Lausanne, Lausanne, Switzerland

¹⁰St Vincent's Institute for Medical Research, Melbourne, VIC, Australia

Aim: To determine the prevalence of isolated T-wave inversion in V2-V3 (TWI_{V2-3}) in different sexes and sporting disciplines, and if TWI_{V2-3} was accompanied by cardiac pathology by analysing a large dataset of elite athlete screening electrocardiograms (ECGs).

Method: Data were obtained from the Australasian Registry of ECGs of National Athletes (ARENA) project and retrospective cohort studies from Australia and New Zealand. Sports included: Olympic sports, Australian football, cricket, soccer, and netball. ECGs were reviewed according to current athlete criteria. Logistic regression calculated odds ratios for the likelihood of TWI_{V2-3}, adjusting for sex and sporting discipline.

Results: Of 4,423 athletes (40% female, age: 19.7±4.5 years), isolated TWI_{V2-3} was found in 36. The finding was four times as common in females compared to males (adjusted OR: 4.2, 95%CI: 2.0–9.5) and endurance athletes versus non-endurance (adjusted OR: 4.8, 95%CI: 2.5–9.5). In total, 34/36 athletes with TWI_{V2-3} underwent follow-up. Details were unavailable for two males. No athletes with isolated TWI_{V2-3} were diagnosed with cardiac disease in 6.4±2.6 years of follow-up.

Female athletes had a higher proportion of abnormal ECGs than males (4.2% vs 2.6%, p=0.004). If TWI_{V2-3} was considered a normal finding in females, female and male athletes would have similar proportions of abnormal ECGs (2.6% vs 2.6%, p=0.95).

Conclusions: Isolated TWI_{V2-3} was four times as common in female athletes compared to males, after adjusting for sporting discipline. This finding was not associated with cardiac pathology. The higher rate of abnormal screening ECGs in female athletes is driven by isolated TWI_{V2-3}.

<https://doi.org/10.1016/j.hlc.2025.06.026>