S99 Abstract

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

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

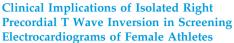
Method: A Markov cohort state-transition model was cycled annually over 25 years for Aboriginal and Torres Strait Islander Australians with CVD and hypercholesterolaemia to receive either Inclisiran and Statin, or statin alone (Figure 1). Transition probabilities, utilities, costs and discounting were 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).

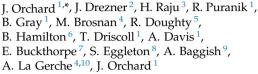
Conclusions: For Aboriginal and Torres Strait Islander Australians with CVD and hypercholesterolaemia, funding Inclisiran first-line with statin, especially when incorporated into a CVD-MOC, may be cost-effective to the Australian healthcare system whilst crucially closing-the-gap in healthcare outcomes.

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Aim: To determine the prevalence of isolated T-wave inversion in V2-V3 (TWI<sub>V2-3</sub>) in different sexes and sporting disciplines, and if TWI<sub>V2-3</sub> 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<sub>V2-3</sub>, adjusting for sex and sporting discipline.

**Results:** Of 4,423 athletes (40% female, age:  $19.7\pm4.5$ years), isolated TWI<sub>V2-3</sub> 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<sub>V2-3</sub> underwent follow-up. Details were unavailable for two males. No athletes with isolated TWI<sub>V2-3</sub> were diagnosed with cardiac disease in

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<sub>V2-3</sub> 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<sub>V2-3</sub>.

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6.4±2.6 years of follow-up.

