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$p=0.97$). There was no correlation between FMD and CFR ($r=0.055$, $p=0.65$). FMD had a significant correlation with the IMR in patients who did not have PCI ($n=18$, $r=-0.52$, $p=0.03$) with no correlation between FMD and IMR in those who had PCI ($n=52$, $r=-0.25$, $p=0.07$). Receiver operating curve analysis revealed area under the curve (AUC) for predischARGE FMD in detecting IMR > 34 was 0.69 (95% CI 0.54-0.83, $p=0.01$), with an optimal FMD cut-off of 8.2% (sensitivity 77.6%, specificity 52.4%). In patients who did not have PCI, the AUC was 0.88 (0.72-1.00, $p=0.0157$) and optimal FMD cut-off was 11.49% (sensitivity 84.6%, specificity 80%).

Conclusions: Brachial artery FMD correlated with IMR of the IRA in NSTEMI. Brachial artery FMD may be a useful non-invasive surrogate for assessing CMD.

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Canagliflozin and Cardiovascular Outcomes in Patients With and Without Peripheral Artery Disease At Baseline: Data from the CANVAS Program and CREDENCE Trials

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Background: Peripheral artery disease (PAD) is the third most common cardiovascular (CV) disease. Patients with Type 2 diabetes mellitus (T2D) and PAD have an increased risk of macrovascular events and death. The SGLT2 inhibitor canagliflozin has well-established CV and renal benefits, however, the benefits and safety in those with PAD remain uncertain.

Methods: We pooled individual participant data categorised by PAD status at baseline from the CANVAS Program ($n=10,142$) and CREDENCE trial ($n=4,401$). The effects of canagliflozin were assessed using Cox regression models with treatment by subgroup interaction terms. Absolute risk reductions were estimated using Poisson regression.

Results: Of 14,543 participants, 3,159 (21.7%) had PAD at baseline. In patients with PAD, canagliflozin reduced major adverse cardiovascular events (MACE) by 24% (hazard ratio [HR], 0.76; 95% confidence interval [CI], 0.62-0.92), hospitalisation for heart failure (HHF) or CV death by 31% (HR, 0.69; 95% CI, 0.56-0.86) and the composite cardiorenal outcome (doubling of serum creatinine, kidney failure, kidney death or CV death) by 27% (HR, 0.73; 95% CI, 0.58-0.91) versus placebo, consistent with patients without PAD (all P heterogeneity > 0.27). Absolute benefits of canagliflozin for MACE and HHF/CV death were greater in those with PAD

as compared to those without PAD. There was no increase in total serious adverse events, amputation or worsening peripheral disease in those with PAD as compared to those without PAD at baseline (p heterogeneity > 0.25).

Conclusion: T2D patients with PAD derive similar relative cardiorenal benefits from canagliflozin treatment but higher absolute benefits as compared to those without PAD.

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Cardiac Device Implantations During COVID-19 Pandemic and Lockdown Period

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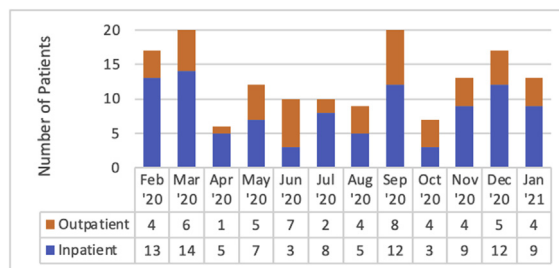
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Background: In the height of the 2020 COVID-19 pandemic, most elective procedures were halted, but pacemakers for symptomatic bradycardia or heart block, or defibrillator for secondary prevention continued as they were essential services. We sought to examine the trends of cardiac device implantations, in hope to derive insights into population health-seeking behaviour during a pandemic.

Methods: All cardiac devices between February 2020 and January 2021 performed at the Northern Hospital were analysed. The number of procedures, including service categories (inpatient vs outpatient) were compared.

Results: A total of 154 devices were performed. A dramatic drop in presentation was observed between April and August 2020. Stage 4 lockdown was introduced in August and lifted only in October 2020. A spike was however observed in September.

Conclusion: The first wave of COVID-19 saw a sharp decline in cardiac implantations/ patient presentations, likely due to health-seeking pattern/ behaviour as patients were probably more reluctant to present in the early months. The spike in September 2020 likely represents delayed presentation, that would otherwise have presented earlier if not for the pandemic.



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