CONCLUSION: In our study, patients treated with Tafamidis had a lower deterioration in ventricular function at 12 months follow-up compared with an untreated group. Although all measures of cardiac function demonstrated a difference in our cohort, indexing GLS to $\sqrt{(RR)}$ may allow assessment in myocardial function in more patients especially in the context of variable RR interval when LVEF measurements can be time consuming and less reliable.

Variable	Without Tafamidis (n=24)	With Tafamidis (n=24)	p-value
Age:	65.67±11.28	72.71±9.64	0.04
Sex:			0.09
Male	15 (62.5%)	21 (87.5%)	
Female	9 (37.5%)	3 (12.5%)	
Comorbidities:			0.96
Smoking	6 (25.0%)	6 (25.0%)	
Alcohol	9 (37.5%)	10 (41.7%)	
Dyslipicemia	10 (41.7%)	14 (58.3%)	
Diabetes	5 (20.8%)	5 (20.8%)	
Hypertension	11 (45.8%)	15 (62.5%)	
Dialysis	1 (4.2%)	0 (0.0%)	
Implanted Device:			0.08
Pacemaker	3 (12.5%)	2 (8.3%)	
ICD	5 (20.8%)	0 (0.0%)	
CRT-D	1 (4.2%)	1 (4.2%)	
None	15 (62.5%)	21 (87.5%)	
Treatmerts:			0.54
Diuretics	10 (41.7%)	15 (62.5%)	
Beta Blocker	9 (37.5%)	11 (45.8%)	
ACE Inhibitor	5 (20.8%)	8 (33.3%)	
ARB	3 (12.5%)	7 (29.2%)	
Digoxin	1 (4.2%)	0 (0.0%)	
MCRA	7 (29.2%)	8 (33.3%)	
Diflunisal	2 (8.3%)	4 (16.7%)	
Other medications	13 (54.2%)	7 (29.2%)	
NYHA Class:			0.07
Asymptomatic	4 (16.7%)	1 (4.2%)	
Class 1	3 (12.5%)	6 (25.0%)	
Class 2	7 (29.2%)	14 (58.3%)	
Class 3	7 (29.2%)	3 (12.5%)	
Class 4	2 (8.3%)	0 (0.0%)	
unknown	1 (4.2%)	0 (0.0%)	
BNP:			
Presenting BNP (pg/mL)	239.31±295.95	195.25±281.20	0.59
BNP Peak (pg/mL)	430.76±593.39	283.00±563.85	0.67
hATTR variants:			0.00011
No variant/wildtype	5 (20.8%)	19 (79.2%)	
Val142Ie	9 (37.5%)	4 (16.7%)	
Thr80Ala	4 (16.7%)	0 (0.0%)	
Val50Met	4 (16.7%)	0 (0.0%)	
Ala120Ser	1 (4.2%)	0 (0.0%)	
Val50Leu	0 (0.0%)	1 (4.2%)	
unknown	1 (4.2%)	0 (0.0%)	

TABLE 1: Descriptive characteristics of 24 patients treated without Tafamidis and 24 patients treated with Tafamidis. P-values were determined by using the Wilcoxon rank-sum test and Fisher's exact test.

P035
EVALUATION OF THE REAL-WORLD PLACE OF THE ICOSAPENT ETHYL (IPE) FOR THE TREATMENT OF PATIENTS WITH HYPERTRIGLYCERIDEMIA REQUIRING INVASIVE CORONARY ANGIOGRAM

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BACKGROUND: Although the REDUCE-IT trial recently demonstrated the benefits of Icosapent ethyl (IPE) on reducing ischemic events in a broad population of primary and secondary prevention patients with hypertriglyceridemia, its generalizability to patients referred for a coronary angiogram is not known yet. This study aims to determine the proportion of patients referred for a coronary angiogram that would be eligible for IPE treatment.

METHODS AND RESULTS: In this prospective study, all patients referred to the catheterization laboratory in a tertiary academic center between January 1st, 2022 and February 15th, 2022 were enrolled. Patients meeting the inclusion criteria of the REDUCE-IT trial were included. A total of 350 patients were screened and included in our study. The average age was 68±11 and 64% were males. Hypertension and diabetes were present in 76% and 40% of patients, respectively. A total of 253 patients (72.3%) had dyslipidemia. The mean left ventricular ejection fraction (LVEF) was 52±14%. A lipid profile was available in 73% of cases in the 6 months preceding the procedure. A total of 38 patients (16.2%) referred to the catheterization laboratory currently on statin therapy would be eligible for IPE, according to REDUCE-IT criteria. No difference was found between patients with acute coronary syndrome and chronic coronary syndrome in terms of elibility for IPE treatment (13.5% vs 21.8%, p=0.132). No eligible patient was yet started on IPE.

CONCLUSION: These analyses would support IPE usage as an adjunct to secondary prevention therapies in eligible patients referred for a coronary angiogram. Findings of this study need to be confirmed in larger scale cohorts.

P036
HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA IN CANADA

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BACKGROUND: Homozygous familial hypercholesterolemia (HoFH) is life-threatening orphan disease characterized by high levels of low-density lipoprotein cholesterol (LDL-C). Untreated patients often present with extensive xanthomas and marked premature atherosclerotic cardiovascular disease (ASCVD) before the age of 20. Prior to the advent of statins and extracorporeal LDL filtration techniques, survival beyond 30 years of age was unusual. Treatment with lipid-lowering therapy is highly efficacious and has dramatically increased life expectancy, reducing the risk of ASCVD to background population rates. Canada is known to have several founder effect regions for HoFH, including Québec. Clinical outcomes in HoFH patients, especially ASCVD events such as myocardial infarctions or stroke are difficult to capture, in part because of the rarity of the disorder and the lack of registry focusing on this disease.

METHODS AND RESULTS: The objective of our project is to obtain a comprehensive registry of HoFH in Canada, estimate the cost to society caused by HoFH burden of disease in Canada, and implement changes to advocate access to specialized care for these patients. A standardized