

**GHANAIAN SOCIETY
OF CARDIOLOGY**





GHANAIAN SOCIETY
OF CARDIOLOGY

2024 ANNUAL GENERAL & SCIENTIFIC MEETING



THEME:

**ATHEROSCLEROTIC
CARDIOVASCULAR
DISEASE: *A Silent Killer***

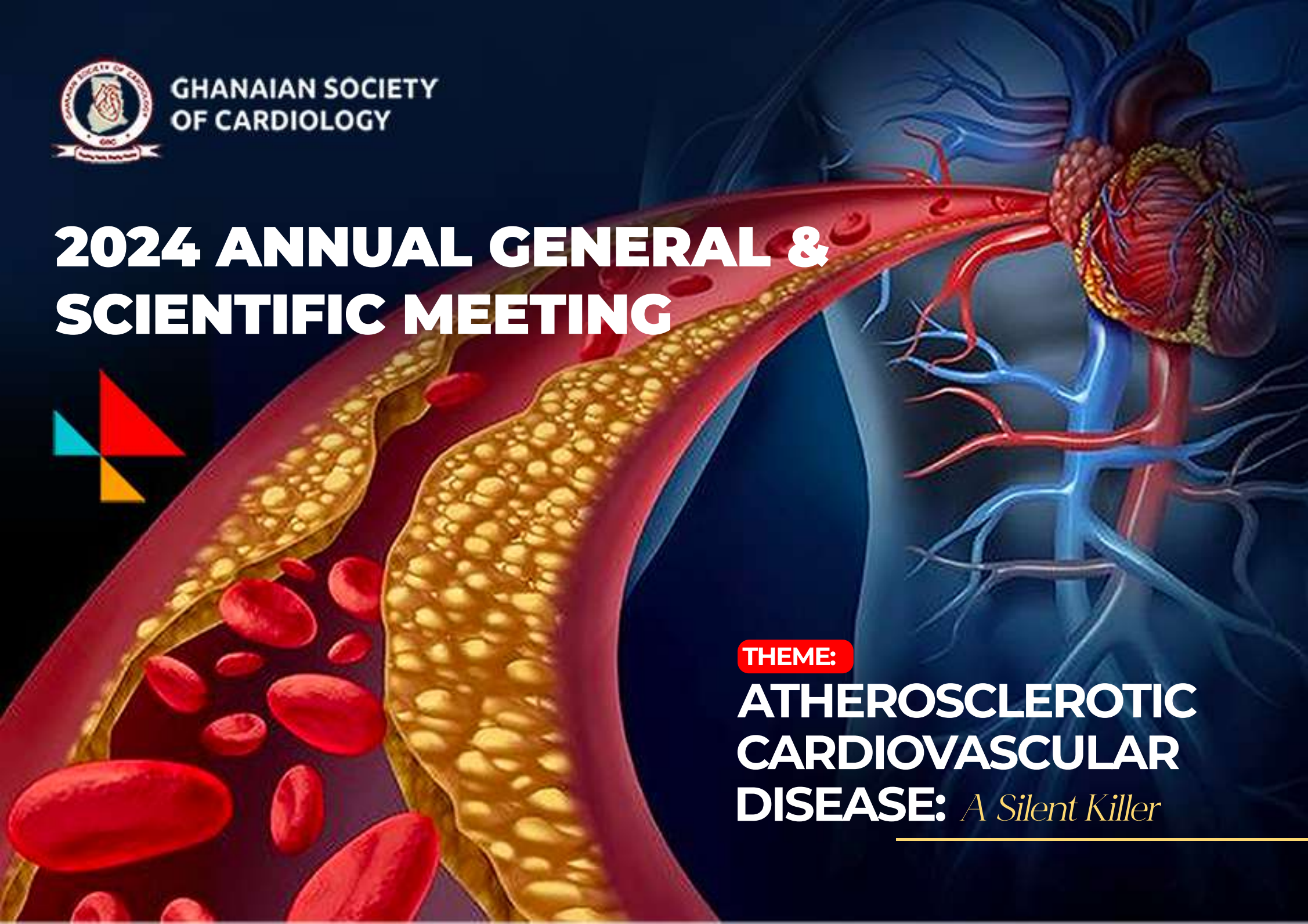
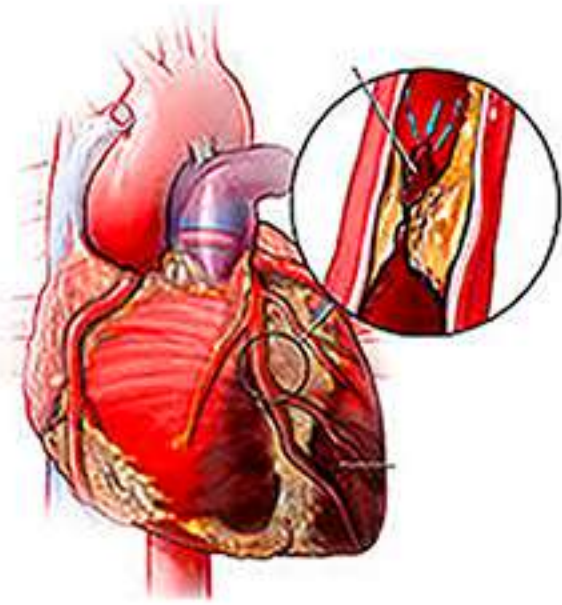


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Participating in the Annual General and Scientific Meeting of the Ghanaian Society of Cardiology offers a valuable platform to stay informed about the latest advancements in the field of cardiology, both at the local and global levels.

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EXECUTIVE SUMMARY



This seminar addresses the silent yet pervasive threat of Atherosclerotic Cardiovascular Disease (ASCVD). Delving into its intricate mechanisms, risk factors, and preventive strategies, the event aims to raise awareness among participants. With insights from leading experts, the seminar navigates through diagnostic advancements,

treatment modalities, and emphasizes the crucial role of lifestyle interventions. By fostering a deeper understanding, the seminar endeavors to empower healthcare professionals and the community in the ongoing battle against this silent killer.



MAIN TOPICS TO BE DISCUSSED

01

ASCVD: Epidemiology, Risk Factors, Pathophysiology, Primary and Secondary Prevention



02

Chronic Coronary Syndrome



03

Carotid Artery Disease and Stroke



04

Erectile Dysfunction



05

Peripheral Artery Disease

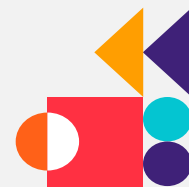


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Imaging in ASCVD



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SPEAKERS & TOPICS



**DR.
ALFRED DOKU**

*ASCD: Epidemiology, Risk Factors,
Pathophysiology, Primary and
Secondary Prevention*



**PROFESSOR
JOSEPH ATIAH AKAMAH**

Chronic Coronary Syndrome



**PROFESSOR
MAYOWA OWOLABI**

Carotid Artery Disease and Stroke



DR. EUGENE AMABLE



**PROFESSOR
NICHOLAS OSEI-GERNING**

Erectile Dysfunction



**DR.
FAFA XEXEMEKU**

Imaging in ASCVD



**DR.
LILY WU**

Peripheral Artery Disease



PROFESSOR I. K. OWUSU

CHAIRPERSONS

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Message from the **LOC Chairman**



DR. FORSTER FOKUOH
LOC CHAIR

It was an honour for me to chair the LOC to organise the 2024 AGSM of our noble society. This year's event is indeed novel, as we bring together a multidisciplinary faculty of distinguished local and international experts to dive into our theme: Atherosclerotic Cardiovascular Diseases: A Silent Killer, from various contexts. We are privileged to have for the first time a scientific component to our AGSM with the presentation of scientific abstracts by some of our esteemed members. We have also leveraged on long-term partnerships with industry to make this AGSM a reality.

I wish to appreciate the executives of the GSC, LOC members, our industry sponsors, and all members of the GSC for their valuable support towards a successful AGSM. May this AGSM be a fruitful event where we will gain more knowledge to better care for our patients with cardiovascular diseases. May we also build meaningful bonds that will catalyse collaborations towards advancing cardiovascular care in Ghana and beyond.

Thank you.

GUEST OF HONOUR



DR. ANTHONY NSIAH-ASARE

of Physicians and Surgeons Council, National Health Insurance Board and Ghana AIDS Commission. Dr. Nsiah-Asare was honored as one of the distinguished health professionals in the country with Presidential Awards as a Member – Order of the Volta in August 2008 and Companion- Order of the Volta in March 2023. Dr. Anthony Nsiah-Asare is happily married with four children.

Dr. Anthony Nsiah-Asare is presently the Presidential Advisor on Health, at the Office of the President of Ghana. Having worked in leadership roles as Medical Superintendent at District hospital, Medical Director at the Regional hospital, Chief Executive Officer at the Teaching Hospital, and Director General of Ghana Health Service, Dr. Nsiah-Asare has created a balance of strategic, operational, business, clinical and health system reform expertise. Dr. Nsiah-Asare qualified from the University of Ghana Medical School with MB,ChB in 1980.

Dr. Nsiah-Asare is a Consultant General Surgeon. He is an alumni of the Boston University, School of Public Health in USA where he obtained his Certificate in Management Methods in International Health. He is a Fellow of the West African College of Surgeons (FWACS), a Fellow of Ghana College of Surgeons (FGCS), a Fellow of International College of Surgeons (FICS) and a Fellow of Ghana Medical Association (GMA). He serves as a Member of the Ghana COVID-19 Taskforce, Presidential Vaccine Production Committee, Garden City University College Council, Kumasi, Chairman of the Cosmopolitan Health Insurance Board and Chairman of Health-GIIF Board for the implementation of Agenda 111. He served on the Ghana Health Service Council, the Ghana College

PROGRAM SCHEDULE DAY 1



PROFESSOR I. K. OWUSU (CHAIRMAN)

8:00AM - 9:30AM

OPENING CEREMONY

- Arrival of Participants
- Welcome Address by Planning Committee and Chairman/Chairman's Remarks
- Welcome Address by President of GSC
- Key Note Address by Guest of Honour
- Fraternity Message from Other Societies



9:30AM - 10:00AM

ASCVD: Epidemiology, Risk Factors, Pathophysiology, Primary and Secondary Prevention

DR. ALFRED DOKU



10:00AM - 10:30AM

Chronic Coronary Syndrome

PROFESSOR JOSEPH ATIAH AKAMAH

10:30AM - 10:45AM

Presentation by GOLD SPONSOR



10:45AM - 11:15AM

Carotid Artery Disease and Stroke
PROFESSOR MAYOWA OWOLABI



Presentation by Sponsor 11:15AM - 10:25AM

11:25AM - 11:45AM **Q & A Session**

11:45AM - 12:00PM **COFFEE BREAK**



12:00PM - 12:30AM

Erectile Dysfunction
PROFESSOR NICHOLAS OSEI-GERNING



12:30AM - 12:40PM

Presentation by Sponsor

12:40PM - 1:00PM **Q & A Session**

1:00PM - 1:10PM **Chairman's Closing Remarks**

1:10PM - 2:00PM **LUNCH BREAK**

4:00PM - 6:00PM
Workshop 1: BLS & ACLS
Workshop 2: Basic ECG Reading

6:00PM **Closing**

Novartis Satellite Event 7:00PM

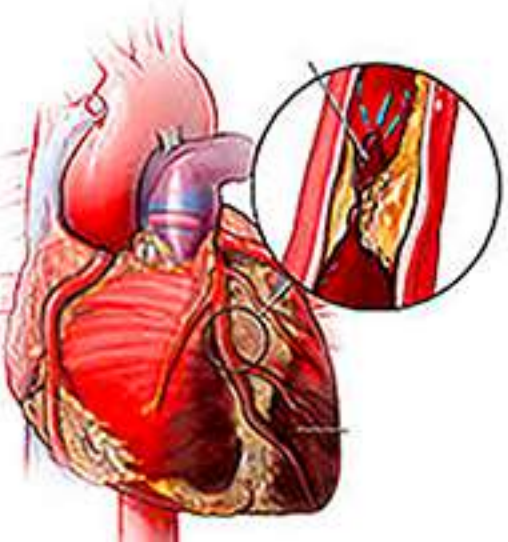
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THEME: ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (A SILENT KILLER)

PROGRAM SCHEDULE DAY 2



DR. EUGENE AMABLE (CHAIRMAN)



8:00AM - 9:20AM

● Arrival of Participants
● Opening Prayer & Introduction of Chairperson
● Chairman's Remarks



9:20AM - 9:50AM
Peripheral Artery Disease
DR. LILY WU

9:50AM - 10:00AM

● Presentation by Sponsor



10:00AM - 10:15AM

● COFFEE BREAK



10:15AM - 10:45AM
Imaging in ASCVD
DR. FAFA XEXEMEKU



10:45AM - 10:55AM

● Presentation by Sponsor

10:55AM - 11:25AM

● Q & A Session

11:30AM - 12:40PM

● Abstract Presentations

12:40PM - 12:50PM

● Presentation by Sponsor



12:50PM - 2:00PM

● Lunch

2:00PM - 4:00PM

● AGSM

4:00PM

● CLOSING

CHAIRMAN'S PROFILE



DR. EUGENE AMABLE

MD, FGCP, FLCP, FWACP

Dr. Eugene Amable is a Consultant Cardiologist and a Fellow of both the Ghana and West Africa College of Physicians. He has worked in the Korle-Bu Teaching Hospital where he has served in various capacities including lecturing in the School of Medicine and Dentistry, and heading the Cardiology Unit in the Department of Medicine.

He has previously held the position of Chief Examiner for the Faculty of Internal Medicine of the Ghana College of Physicians. He has served in many other capacities on a national scale and has been instrumental in training many physicians and cardiologists in this country.

CHAIRMAN'S PROFILE



PROFESSOR ISAAC OWUSU

BSc., MBCh.B., Dip PDM, FWACP, FGCP

Professor Isaac Owusu is a Consultant Cardiologist and the Head of the Department of Medicine, School of Medicine and Dentistry, College of Health Sciences, Kwame Nkrumah University of Sciences and Technology, Kumasi, Ghana. He is a Fellow of both the Ghana and West Africa College of Physicians and an Associate Professor of Medicine.

He is an astute researcher with publications in several journals on subject areas such as Hypertension and Heart Failure in Ghana. He has been instrumental in establishing Cardiology as a subspecialty in Ghana, having trained many Cardiologists locally. He is a past president of the Ghanaian Society of Cardiology, and has been very instrumental in building the society from its inception to date.

SPEAKER PROFILE



DR. ALFRED DOKU

Fellow German Cardiac Society, FWACP,

FGCPS Country Director, Ghana Heart Initiative

Director, African Air Ambulance Foundation

Head of Cardiology, UGMS/KBTH

Immediate Past President, Ghanaian Society of Cardiology

Dr. Alfred Doku trained in SMS, KNUST and graduated in 1997 with MBChB. He joined the Korle-Bu Teaching Hospital in 1999 and has worked there for 23 years. He had his Cardiology Fellowship training in Ghana and Germany, and is now a Consultant Cardiologist, Internist and Senior Lecturer with the University of Ghana Medical School (since 2016). For over twenty years, Dr. Doku has been in the forefront of the fight against cardiovascular diseases.

He partnered with senior colleagues to form the Ghanaian Society of Hypertension and Cardiology (GHASHCAR) in 2003 for which he became the maiden Secretary General. Through this society, he organized nationwide campaigns to fight cardiovascular diseases through World Heart Day celebrations, International Update Courses in Cardiology, cardiology seminars and symposia to create awareness among both the general public and the staff of the health systems to fight CVD by mobilizing the media, cooperate Ghana with their CSR, pharmaceutical companies, the MOH/GHS, WHO, the National Cardiothoracic Centre, Ghanaian Medical Students Association, etc

Through the initiative, National Guideline for the Management of CVD, training manual and facilitators guide for CVD, Akomacare APP for ease of use of CVD guidelines, training of health professionals in BLS/ACLS and CVD as well as equipment support that will improve CVD care in over 190 health facilities and involving close to 2000 health workers.

SPEAKER PROFILE



PROFESSOR MAYOWA OWOLABI

FMCP, FWACP, FAAN, FANA, FAHA, FRCP, FAAS, FAMedS, FAS Professor of Neurology; pioneer Director, Center for Genomic and Precision Medicine, College of Medicine, University of Ibadan; Honorary Consultant Neurologist, University College Hospital, Ibadan, Nigeria.

Professor Mayowa Owolabi is an eminent scholar with a stroke phenotyping software patent and over 400 publications in peer-reviewed reputable journals. He is a recognized global leader in medicine, neurology, cardiovascular diseases, neuro-rehabilitation, global health, brain health, community-based genomic epidemiology of stroke in Africa, clinical trials and implementation science. He is an outstanding scientist with several inventions and innovations including the 'Seed of Life Model' a conceptual model of holistic essence and quality of life; the HRQOLISP, a multiculturally-validated quality of life measure for stroke, amongst several others.

He unraveled the dominant risk genetic and non-genetic risk factors for stroke in Africa and discovered the protective effect of green leafy vegetables against stroke and hypertension. He led the SIREN team as the first to discover the association between APOL 1 and small vessel disease stroke. He also led the discovery of genome-wide association of microRNA and stroke in Africans and the development of prediction models for stroke and hypertension in Africa.

He is among the global top 2% scientists (2023) and the winner of the 2021 World Stroke Organization Global Award for Outstanding Contributions to Clinical Stroke Research. He is currently leading the implementation call for action against hypertension in Africa working with the World Hypertension League, World Health Organization and Resolve To Save Lives.



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SPEAKER PROFILE



DR. LILY WU

BSc., MBChB, MSc, MGCS, FWACS, MPhil

Consultant Vascular Surgeon

Dr. Lily Pincho Wu is a Consultant Vascular Surgeon and Endovascular Interventionist at the Korle Bu Teaching Hospital (KBTH). She is also a part-time lecturer in Surgery, School of Medicine and Dentistry, College of Health Sciences, University of Ghana and Accra College of Medicine, Ghana. She is a member of the European Society of Vascular Surgery, Vascular Society of Southern Africa, the Health Professionals Council of South Africa, a fellow of the WACS and a member of Ghana college of Surgeons and Physicians. She also holds an MPhil in Vascular Surgery from the University of Cape Town.

She is a member of the National Medicines Selection Committee for the drafting and review of essential drug list. From 2013 to 2015 she was the Chairperson of the Ethics and Professionalism Committee, a member of the Senior Staff Disciplinary Committee, and a member of the Quality Assurance Committee at the Korle Bu Teaching Hospital.

She has won a number of awards including the Gold medal award for Innovation at the maiden edition of the KORLE BU INNOVATION SUMIT in 2020. She also won a gold medal for the Best Performing Candidate in the Vascular Surgery Examinations, South Africa, VASSA – 2017 and Gold medal for best performance in General Surgery- FWACS – 2011. As a medical student, she was the best over-all student, MBChB Part 1, SMD, CHS, Univ. of Ghana, 2001 and was honoured with the University of Ghana Vice-chancellor's recognition for outstanding performance, 1997.

SPEAKER PROFILE



FAFA XEXEMEKU

MD, FACC, RPVI, MWACP

Fafa Xexemeku is a board-certified multimodality cardiovascular imaging cardiologist at the Mercyhealth Heart and Vascular Center in Janesville, Wisconsin where he started and directs the Cardiovascular Magnetic Resonance and Computerized Tomography Programs.

He also serves as head of the Echocardiography Laboratory. Dr. Xexemeku received his medical degree from the University of Ghana Medical School. He completed an internal Medicine residency in Ghana and is a member of the West Africa College of Physicians. After moving to the United States, he trained in internal Medicine and Cardiovascular Medicine at Bridgeport Hospital/Yale University.

Dr. Xexemeku then completed a Cardiac MRI fellowship at the Barts Heart Centre/University College of London. Prior to his current position, he established and directed the adult Cardiovascular Magnetic Resonance Program at the Crouse Hospital Miron Cardiac Care Center in Syracuse, New York.

Dr. Xexemeku holds board certifications in Cardiovascular Medicine, Echocardiography, Nuclear Cardiology, Cardiovascular Magnetic Resonance, Cardiovascular Computed Tomography, and Vascular Ultrasound.

SPEAKER PROFILE



JOSEPH ATIAH AKAMAH,

*MB. ChB, MPH, MBA, FACP, FACC,
FSCAI, FGCPS Adjunct Associate
Professor of Medicine, Meharry
Medical College Medical Director,
Cardiology, and Interventional
Cardiology, NGH*

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Dr. Joseph Atiah Akamah is the Medical Director for Cardiovascular and Interventional Cardiology Services at the Nashville General Hospital, Tennessee, USA. He is an Adjunct Associate Professor at the Department of Medicine, Meharry Medical College, where he is engaged in helping with cardiovascular medicine training and mentorship for medical students and residents.

Dr Akamah graduated from UGMS in 1993 with two top awards in Surgery. After 2 years of surgery and emergency medicine in the UK, he moved to the USA where he trained and worked at Cook County Hospital in Chicago before moving to Nashville in 2007. In 2013, Dr Akamah left USA on a mission to help train cardiologists and middle level personnel in his native country, Ghana. He rose to the rank of Head of Cardiology at the University of Ghana. During his tenure as Head of Cardiology and together with his colleagues, he revamped and reshaped both general cardiology and interventional cardiology training and practice in Ghana. Prior to this he served as consultant cardiologist at the Ministry of Health and Deputy CEO of the National Ambulance Services. Dr Akamah chaired the maiden HeFRA committee for the certification of cardiology clinics in Ghana.

He is experienced, well-trained, board certified and licensed in multiple medical and cardiovascular specialties and recognized internationally. Dr Akamah is a fellow of the Society for Cardiovascular Angiography and Interventions, American College of Cardiology, and the American College of Physicians and internationally, he is a fellow of Ghana College of Physicians and Surgeons. He is a member of the Ghana Physicians and Surgeons Foundation of North America and the Association of Black Cardiologist. Dr Akamah loves to teach, share, guide and innovate in resource poor situations. His self-sacrificing and receptive personality to all has earned him admiration from both peers and subordinates, drawing many close to him for mentoring and guidance. He sees all patients with heart problems ranging from blood pressure to heart failure as well as those with clogged arteries. His work as an interventionalist; unclogging arteries with angioplasty and stents, is impeccable. His student pool is vast, ranging from emergency technicians, critical care nurses and cardiac catheterization laboratory staff to medical students, doctors and trainee interventional cardiologists. Above all, his patients love him.

SPEAKER PROFILE



PROFESSOR NICK OSEI-GERNING

*MD, FRCP, OBE
Professor of Practice,
University of Wales, TSD
Professor of Cardiology and
Pudendology UCC, Ghana
Consultant Interventional Cardiologist, The
Grange University Hospital, South Wales
New Year King's Order of the British Empire*

Professor Nick Osei-Gerning is an accomplished Ghanaian Interventional Cardiologist working with Gloucestershire Hospital Foundation NHS Trust and a faculty of the Ghanaian Society of Cardiology. He has played a key role in advancing cardiovascular care in Ghana, Africa, and internationally through his clinical expertise and speaking engagements. He is a leading authority on vasculogenic erectile dysfunction (ED) and a member of the British, European and International Societies for Sexual Medicine and was also elected to be a member of the International Consultation for Urological Diseases. As an Interventional Cardiologist, he has travelled extensively - both nationally and internationally, to speak on the same.

He is a regular faculty member of the British and European Cardiac Interventional Societies and a Co-Course Director of Africa Percutaneous Revascularisation. He plays many other roles both nationally and internationally, in line with his passion for improving cardiovascular care locally and globally.

SCIENTIFIC ABSTRACT 1

Comparative Echocardiographic Assessment of Cardiac Function Among Patients with Chronic Kidney Disease and those with Systemic Hypertension in Korle-Bu Teaching Hospital

George Peprah¹, Alfred Doku², Vincent Boima²

¹Takoradi Hospital, Western Region, Ghana

²University of Ghana Medical School, Greater Accra Region, Ghana

BACKGROUND

This study aimed to assess the prevalence of cardiac abnormalities in chronic kidney disease (CKD) stages 3 to 5 patients, compared to patients with hypertension (without CKD). Additionally, analysis of only the CKD patients was done to explore associations between cardiac abnormalities and age, diabetes, dialysis, and CKD stage.

METHODS

The study compared 78 CKD patients and 83 hypertensive patients at Korle Bu Teaching Hospital. It included adults aged 30 to 75 diagnosed with CKD stages 3 to 5, with no prior congenital cardiac abnormality. Baseline demographic and clinical characteristics were assessed, and echocardiograms were performed to determine the prevalence of common cardiac pathologies. Multiple binary logistic regression models were fitted for each of the cardiac abnormalities measured, serving as outcome variables and sex, age, diabetes status, dialysis status and stage of CKD as the explanatory variables.

RESULTS

The prevalence of left ventricular hypertrophy (LVH), Left ventricular diastolic dysfunction (LVDD), left atrial enlargement (LAE), and pericardial effusion were significantly higher in patients with CKD stages 3 to 5 compared to patients with hypertension. There was no disparity in the prevalence of pulmonary hypertension (PH) and LVSD among patients with CKD or hypertension. Increasing CKD stage increased the prevalence of LVH and LAE but not LVSD and PH. Patients with stage 5 CKD had a more severe form of diastolic dysfunction, grade 2 and 3 LVDD, though it did not meet statistical significance.

CONCLUSIONS

Participants with CKD showed a higher prevalence of LVH, particularly concentric LVH, than those with systemic hypertension.

SCIENTIFIC ABSTRACT 2

QUALITY OF CARE AND INPATIENT OUTCOMES OF PATIENTS SEEN WITH ACUTE CORONARY SYNDROME AT TAMALE TEACHING HOSPITAL

Abdul-Subulr Yakubu¹, Dzifa Ahadzī¹

¹Department of Internal Medicine, Tamale Teaching Hospital, Tamale, Ghana

Background

African countries are facing an epidemic of cardiovascular diseases. Information on the quality of acute coronary syndrome care offered in underserved communities in Ghana is limited. Using objective criteria, we examined the quality of care offered to patients presenting with acute coronary syndrome to a tertiary referral centre in Northern Ghana.

METHODS

We conducted a retrospective review of patients ≥ 18 years old with acute coronary syndrome managed in Tamale Teaching Hospital from January 2021 to December 2022. We assessed in-hospital outcomes and the extent of compliance to key performance and quality indicators as contained in the 2017 American Heart Association/American College of Cardiology guideline for adults with myocardial infarction.

RESULTS

62 patients with a mean age of 56.0 ± 16.1 years were recruited. The

median delay to presentation was 24 hours (IQR 15-96 hours). 33.9% had ST-elevation myocardial infarction, of which only 14.3% received reperfusion therapy. About three-quarters of patients received dual antiplatelet therapy at discharge, with fewer patients receiving recommended high-intensity statin therapy (65.5%) or beta-blockers (69.1%). Only 38.2% of patients had their left ventricular ejection fraction documented. No cardiac rehabilitation program existed. Risk stratification of patients with non-ST-elevation myocardial infarction or stress testing for conservatively managed patients was not part of routine practice.

CONCLUSION

Acute coronary syndrome management remains a challenging issue in Northern Ghana. Several gaps exist in the quality of care, timeliness of interventions and rehabilitation of affected patients.

Keywords:

Acute coronary syndrome, Ghana, Myocardial infarction, Performance measure, Quality indicators

SCIENTIFIC ABSTRACT 3

EVALUATION OF CARDIAC STRUCTURE AND FUNCTION AMONG STUDENT-ATHLETES AT THE UNIVERSITY OF GHANA, LEGON

Richard S. Dey¹, Joseph A. Akamah², Alfred Doku³, Francis Agyekum³, Setor K. Kunutsor⁴, Robert Ayree⁵, Gloria Ansa¹

¹University of Ghana Hospital, Accra

²Nashville General Hospital, USA

³University of Ghana Medical School, Accra

⁴University of Leicester, UK

⁵University of Ghana Medical Centre, Accra

INTRODUCTION:

Electrocardiographic and echocardiographic changes are expected in athletes, reflecting structural and electrical remodelling due to physiologic adaptations in the heart to cope with increased demand. Cardiac screening remains rare among athletes in sub-Saharan Africa. This study aimed to assess the electrocardiographic (ECG) and echocardiographic (ECHO) patterns and factors associated with changes in the patterns among student-athletes at the University of Ghana, Legon.

METHOD:

A comparative cross-sectional study was conducted among student-athletes, and age and sex matched control. Baseline demographic and clinical characteristics of participants were obtained. Focused history, physical examination, ECG, and ECHO examination were performed on each participant to determine the pattern and the prevalence of ECG and ECHO changes among student-athletes. The variance of mean differences between the student-athletes and the controls was determined. Associations between categorical variables and factors associated with ECG and ECHO changes among the student-athletes were determined. Potential confounding factors were

accounted for in the multivariate logistic regression models with adjusted odds ratio and confidence interval.

RESULTS:

About 47% of athletes had ECG changes, which consisted of PVCs, atrial fibrillation, ST-segment depression, T-wave inversion, bradycardia and LVH. Males were about 4.6 times more likely to have ECG changes than females in a fully adjusted model ($p=0.001$). The prevalence of concentric LV remodelling, concentric LV hypertrophy, and eccentric LV hypertrophy in the student-athletes was 36.5%, 33.9% and 8.7%, respectively, significantly higher ($p<0.001$) than in the control group. None of the factors in the models were significantly associated with abnormal LV geometry in the student-athletes.

CONCLUSION:

Student-athletes had abnormal ECGs, with the male gender being the only predictor of abnormal ECGs. Routine screening of athletes may detect life-threatening cardiovascular conditions that may predispose them to sudden cardiac death.

SCIENTIFIC ABSTRACT 4

CLINICAL PROFILES OF HEART FAILURE IN PREGNANT AND POSTPARTUM WOMEN ADMITTED INTO A TERTIARY HOSPITAL IN ACCRA.

A. Bobbie- Sarfo¹, R. Aryee², C. Antwi- Bosiako³, V. Ganu⁴, F. Agyekum^{3,4}, J. Akamah³, A. Doku^{3,4}

¹Greater Accra Regional Hospital, Accra

²University of Ghana Medical Centre, Accra

³University of Ghana Medical School, Accra

⁴Korle Bu Teaching Hospital, Accra

BACKGROUND

Cardiac deaths from heart failure (HF) during pregnancy and the postpartum period is an important indirect cause of maternal mortality. There is limited data on heart failure in pregnancy in Ghana. This study therefore sought to assess the aetiology and clinical presentation of heart failure among pregnant and postpartum women admitted into the Korle-Bu Teaching Hospital.

METHODS

This study was carried out in the obstetric and medical wards of the Korle-Bu Teaching Hospital. It was a cross-sectional study, recruiting 131 consecutive pregnant and up to 6-months postpartum women with suspected heart failure confirmed using the Framingham's criteria. A structured questionnaire was used to obtain details of history and physical examination as well as electrocardiographic and echocardiographic findings and analysed using IBM SPSS version 24

software. P-value less than 0.05 at a confidence interval of 95% was considered statistically significant.

RESULTS

The prevalence of heart failure in pregnancy was 0.9%. The commonest risk factor for heart failure among the participants was a past history of PIH/pre-eclampsia/eclampsia. Peripartum cardiomyopathy was the commonest aetiology of heart failure. The commonest ECG finding was sinus tachycardia. Patients with peripartum cardiomyopathy predominantly had heart failure with reduced ejection fraction (HFrEF). The period of time from delivery to the end of puerperium was found to be a high risk period for cardiac decompensation.

CONCLUSION

Pregnant women with a previous history of PIH were at highest risk of developing heart failure within the puerperium; strict surveillance is needed on this patient population.

SCIENTIFIC ABSTRACT 5

CARDIAC ABNORMALITIES AMONG SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS IN A TERTIARY HOSPITAL: A CROSS-SECTIONAL STUDY.

S. Attuquayefio¹, A. Doku², D. Dey³, F. Agyekum⁴, F.K. Akumiah², A.G. Kwek⁵, U.M. Amaechi⁶, H.O. Aiwuyo⁷

¹Internal Medicine, University of Ghana Medical Centre, Accra, GHA.

²Internal Medicine, Korle-Bu Teaching Hospital, Accra, GHA.

³Internal Medicine and Therapeutics, University of Ghana Medical School, Accra, GHA.

⁴Internal Medicine, University of Ghana Medical School, Accra, GHA.

⁵Internal Medicine/Cardiology, Colchester Hospital, East Suffolk and North Essex NHS Foundation Trust (ESNEFT), Colchester, GBR.

⁶Internal Medicine, Lagos University Teaching Hospital, Lagos, NGA.

⁷Internal Medicine, Brookdale University Hospital and Medical Center, Brooklyn, USA.

BACKGROUND

Systemic lupus erythematosus (SLE) is a multisystem autoimmune connective tissue disorder involving multiple organs and systems. Although cardiovascular involvement in SLE patients is a major cause of morbidity and mortality, they are rarely screened for. This study determined the prevalence of cardiac abnormalities among SLE patients and its association with the modified SLE Disease Activity Index 2000 (modified SLEDAI-2K).

METHODS

This was a cross-sectional study of SLE patients (≥ 18 years) with no known cardiac abnormalities at the KBTH, from June to December 2021. The baseline demographic and clinical characteristics were obtained. A detailed transthoracic echocardiogram was performed for all patients. The prevalence of common cardiac pathologies was determined and compared between those

with a high modified SLEDAI-2K and those with a low modified SLEDAI-2K.

RESULTS

Ninety-nine SLE patients participated in the study with a mean age of 35.12(± 12.62) years. Majority of the participants (90.9%) were females. The mean modified SLEDAI-2K score was 9.1. Thirty-five percent (35%) of the patients had mild to moderately active disease and 39% had severely active disease. Sixty-six percent (66%) out of the severely active disease group had abnormal echocardiographic findings, while 28% of those with mild to moderate disease had abnormal echocardiographic findings. Echocardiographic abnormalities were found in 56(47%) patients, of which 8.7% had valvular involvement, 15.7% had diastolic dysfunction, 5.2% had LVH, and 0.9% LVSD. About 12% had PH and 1% had pericardial involvement (pericardial effusion and pericardial thickening). The odds of echocardiographic abnormalities were 13.7 times higher in SLE patients with high disease activity compared to those with low disease activity (OR = 13.714, 95% CI=3.804-49.442, $p < 0.001$). There was no significant association between cardiac abnormalities and SLE duration, and modified SLEDAI-2K score.

Figure 1: Prevalence of subclinical echocardiographic abnormalities

Table 2: Logistic regression analysis of disease activity and echocardiographic abnormalities in SLE patients

Variable	OR	95% CI	p-value
Model 1	13.714	3.804 - 49.442	<0.001
Model 2	10.206	2.714 - 38.381	0.001

Model 1 was unadjusted; Model 2 was adjusted for age, systolic and diastolic blood pressures

Conclusion:

Cardiac abnormalities are common in SLE patients. Echocardiographic assessment should be considered in the management of SLE patients.

SCIENTIFIC ABSTRACT 5-CONT.

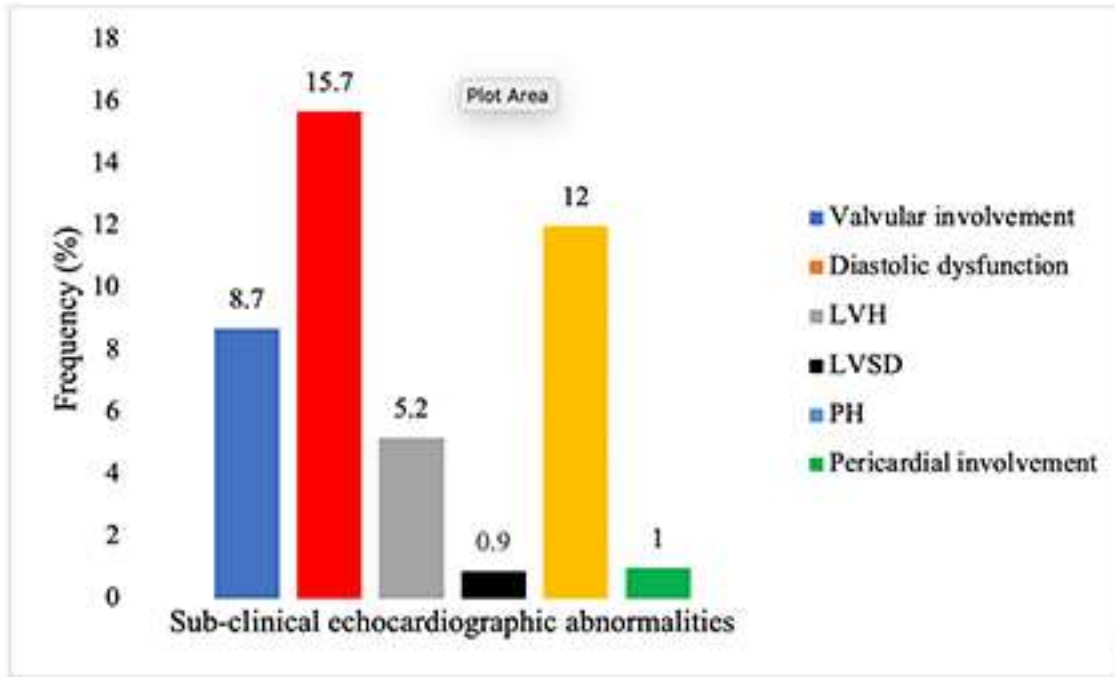


Figure 1: Prevalence of subclinical echocardiographic abnormalities

CONCLUSION:

Cardiac abnormalities are common in SLE patients. Echocardiographic assessment should be considered in the management of SLE patients.

Table 2: Logistic regression analysis of disease activity and echocardiographic abnormalities in SLE patients

Variable	OR	95% CI	p-value
Model 1	13.714	3.804 - 49.442	<0.001
Model 2	10.206	2.714 - 38.381	0.001

Model 1 was unadjusted; Model 2 was adjusted for age, systolic and diastolic blood pressures

EXECUTIVES



DR. COLLINS KOKURO
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DR. FRANCIS AGYEKUM
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DR. DZIFA AHADZI
(ORGANISING SECRETARY)



DR. ABA FOLSON
(TREASURER)



DR. ALFRED DOKU
(EX-OFFICIO MEMBER)



DR. CYRIL OFORI
(EX-OFFICIO MEMBER)



**DR. EMMANUEL NAA
DEEDEI TAGOE**
(FELLOW IN TRAINING)

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Totally of evidence for Forxiga™ strengthens the importance of early use in patients with T2DM¹

T2D could be damaging for heart and kidneys now²

DECLARE Forxiga™ demonstrated vs. placebo:

27%^{*}**
 In Hospitalization for Heart Failure³
vs. Placebo, HR 0.73, 95% CI 0.58, 0.93
 Forxiga demonstrated lower rates
 for a clinically significant outcome compared
 to the placebo group

47%^{*}**
 In progression to nephropathy⁴
vs. Placebo, HR 0.53, 95% CI 0.35, 0.80
 Forxiga demonstrated significantly reduced
 rates of nephropathy compared to placebo

Prefer Forxiga™ today for your everyday patient. Your treatment choice today can change your patient's outcome tomorrow.

Simple dosing and administration

START WITH MORE CONTROL WITH MORE
Forxiga 5mg and 10mg tablets

Convenient, once-daily dosing | **10mg tablet**

- One tablet, taken any time of day, with or without food
- No titration or dose adjustment required⁵
- SPR and NDA in process, with SPR and NDA in India and Singapore^{6,7}

1. Diabetes Care. 2023;46(12):2003-2011. 2. Diabetes Care. 2023;46(12):2003-2011. 3. Diabetes Care. 2023;46(12):2003-2011. 4. Diabetes Care. 2023;46(12):2003-2011. 5. Diabetes Care. 2023;46(12):2003-2011. 6. Diabetes Care. 2023;46(12):2003-2011. 7. Diabetes Care. 2023;46(12):2003-2011.

FORXIGA offers simple dosing and administration¹

10mg tablet

- CONVENIENT ONCE DAILY DOSING
- NO TITRATION REQUIRED⁵
- WITH OR WITHOUT FOOD

- FOR BETA-BLOCKING CONTROL:**
 FORXIGA is indicated for the treatment of insufficiently controlled T2D in adults as an adjunct to diet and exercise.¹ Initiate 10mg dose for patients with T2D, and if eGFR falls below 45 mL/min, consider additional glucose-lowering treatment as needed.¹
- FOR HF/HFpEF:**
 FORXIGA is indicated for the treatment of symptomatic chronic HF/HFpEF in adult patients, with or without T2D.¹ Initiate 10mg dose if eGFR > 30 mL/min/1.73m² (based on clinical trial data).¹
- FOR CHRONIC KIDNEY DISEASE:**
 FORXIGA is indicated for the treatment of chronic kidney disease in adult patients, with or without T2D.¹ Initiate 10mg dose if eGFR > 25 mL/min/1.73m². Patient may continue on FORXIGA 10mg once daily if eGFR falls below 25 mL/min/1.73m² (based on clinical trial data).¹

1. Forxiga (dapagliflozin) tablets, 5 mg and 10 mg, AstraZeneca. 2. Forxiga (dapagliflozin) tablets, 5 mg and 10 mg, AstraZeneca. 3. Forxiga (dapagliflozin) tablets, 5 mg and 10 mg, AstraZeneca. 4. Forxiga (dapagliflozin) tablets, 5 mg and 10 mg, AstraZeneca. 5. Forxiga (dapagliflozin) tablets, 5 mg and 10 mg, AstraZeneca. 6. Forxiga (dapagliflozin) tablets, 5 mg and 10 mg, AstraZeneca. 7. Forxiga (dapagliflozin) tablets, 5 mg and 10 mg, AstraZeneca.



Forxiga™ 5 mg, 10 mg Film-coated Tablets. Each 5 mg and 10 mg tablet contains dapagliflozin propionate mesylate equivalent to 5 mg and 10 mg dapagliflozin respectively. Excipient with known effect: Each 5 mg and 10 mg tablet contains 25 mg and 50 mg of lactose anhydrous respectively. **PHARMACEUTICAL FORM:** Film-coated tablet. **THERAPEUTIC INDICATIONS:** Type 2 diabetes mellitus: Forxiga™ is indicated in adults aged 18 years and older with type 2 diabetes mellitus to improve glycaemic control as: Monotherapy: When diet and exercise alone do not provide adequate glycaemic control in patients for whom use of metformin is considered inappropriate due to intolerance. Add-on combination therapy: In combination with other glucose-lowering medicinal products including insulin, when these, together with diet and exercise, do not provide adequate glycaemic control. Heart Failure: Forxiga™ is indicated in adults for the treatment of symptomatic chronic heart failure with reduced ejection fraction. Chronic Kidney Disease: Forxiga™ is indicated in adults for the treatment of chronic kidney disease. For full prescribing information refer to the Standard Export Leaflet approved by the medicines regulatory authority. Forxiga™ is a trademark of the AstraZeneca group of companies. www.astrazeneca.com. Tel: +27 (0)11 797-6000. Fax: +27 (0)11 797-6001.

Reference

1. FORXIGA 5 mg and 10 mg film-coated tablets. Prescribing information.

Adverse events, Medical information and Product quality complaints should be reported at patientsafety@astrazeneca.com

Approval Code: X5-2771
 Date of Preparation: May 2023
 Date of Expiry: May 2024



AstraZeneca Pharmaceuticals Pvt. Ltd. Building 2, Northdowns OfficePark, 17 Georgian Crescent West, Bryanston, 2191, South Africa. Private Bag 322, Bryanston, 2021, South Africa.



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A COMPLETE PORTFOLIO
to address your structural heart procedure

GE's Interventional Image-Guided Systems (IGS) and Cardiovascular Ultrasound (Vivid™ series) are aimed to fit a wide range of cardiovascular needs and applications which will help you achieve desired outcomes:

- Increase Patient and Staff Safety**
 - Interventional IGS includes beam-forming and beam steering to reduce radiation dose to the patient and staff.
 - IGS includes safety features such as automatic exposure control and dose rate monitoring.
- Improve Operational Efficiency**
 - Interventional IGS includes a wide range of applications for TAVI, MitraClip, and transcatheter aortic valve replacement (TAVR).
 - IGS includes features such as auto-tracking and auto-centering to reduce procedure time.
- Enhance Clinical Confidence**
 - Interventional IGS includes a wide range of applications for TAVI, MitraClip, and transcatheter aortic valve replacement (TAVR).
 - IGS includes features such as auto-tracking and auto-centering to reduce procedure time.

GE Healthcare's Image-Guided Systems and Cardiovascular Ultrasound work together to achieve workflow efficiency in structural heart procedures by utilizing fusion technology for enhanced communication, planning and navigation.

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Work in 3D with iQon™ 3D for enhanced visualization.

iQon™ 3D
The perfect solution for complex structures.

Discovery™ HD 750
Reduce your procedure time with Discovery™ HD 750.

iQon™ 3D
Work in 3D with iQon™ 3D for enhanced visualization.

iQon™ 3D
The perfect solution for complex structures.

Discovery™ HD 750
Reduce your procedure time with Discovery™ HD 750.

In addition to the above you can benefit from a suite of added GE service products:

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Delivers comprehensive end-to-end management of your interventional suite, from acquisition to storage, maintenance, training, and service.
- OnWatch**
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- iGite**
A service platform designed for you, when you need it.

Contact your local GE representative to learn more on how we can help you make your patient and staff's safety, while increasing confidence and efficiency.

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- 25%** reduction in cardiovascular mortality
- 30%** reduction in heart failure hospitalizations
- 50%** reduction in cardiovascular mortality

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Jardiance®
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In the treatment of patients with aHFrEF

EMPOWERED BY YOU. POWERED BY JARDIANCE.

- Proven Efficacy**
- 25% reduction in cardiovascular mortality
- 30% reduction in heart failure hospitalizations
- 50% reduction in cardiovascular mortality
- Enhanced Safety and Tolerability Profile**
- Simple Dosing**
Once-daily dosing with no restrictions



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Protection never rests
The support your patients need day in and day out

Xarelto® globally approved in 9 indications including:

Stroke prevention in atrial fibrillation (AF)

- Around the world, there are **12.2 Million**, new strokes per year, **ONE EVERY 3 SECONDS!**
- **101 Million** people worldwide are living with stroke aftermath. **THIS NUMBER HAS ALMOST DOUBLED OVER THE LAST 30 YEARS!**

Venous thromboembolism

- There are **10 Million**, cases of VTE worldwide each year!
- In fact, every **37 seconds**, someone in the western world dies of a 'blood clot'!









References: 1. Stroke. 2016; 45(12):2284-2292. 2. Stroke. 2016; 45(12):2284-2292. 3. Stroke. 2016; 45(12):2284-2292. 4. Stroke. 2016; 45(12):2284-2292. 5. Stroke. 2016; 45(12):2284-2292. 6. Stroke. 2016; 45(12):2284-2292. 7. Stroke. 2016; 45(12):2284-2292. 8. Stroke. 2016; 45(12):2284-2292. 9. Stroke. 2016; 45(12):2284-2292. © Bayer Ltd, Wroclaw 102, August 2023



Axaban-Denk 5 mg Axaban-Denk 2.5 mg

-  **No need for routine laboratory monitoring (INR), unlike VKA¹**
-  **Superior safety and effectiveness profile, compared with warfarin and other VKAs^{2,3}**
-  **Significant relative risk reduction in major bleeding compared to Enoxaparin/Warfarin^{4,5}**
-  **Can be taken with or without food, has no specific food restrictions and may be crushed and suspended in water or juice for better patient compliance^{4,5}**

1/ Wang L, et al. Drugs. 2015; 75(12):1151-1160. 2/ Wang L, et al. Stroke. 2015; 46(12):3588-3594. 3/ Pan-Genic L, et al. Stroke. 2012; 43(12):2284-2292. 4/ Wang L, et al. Stroke. 2015; 46(12):3588-3594. 5/ Wang L, et al. Stroke. 2015; 46(12):3588-3594.

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TRIPLIXAM
perindopril arginine | indapamide | amlodipine

The Triple Therapy
for more power¹



Perindopril arginine
Indapamide
Amlodipine

Perindopril arginine	5 mg	5 mg	10 mg	10 mg
Indapamide	1.25 mg	1.25 mg	2.5 mg	2.5 mg
Amlodipine	5 mg	10 mg	5 mg	10 mg

4 AVAILABLE
DOSAGES

1 Tablet / Day^{*}

INDICATION²: Substitution therapy for treatment of essential hypertension, in patients already controlled with perindopril/indapamide fixed dose combination and amlodipine, taken at the same dose level.

^{*} For complete information, please refer to the Summaries of Product Characteristics for your country.

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1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100



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As a strong complement to a maximally tolerated statin¹

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INITIATE SYBRAVA[®]
(inclisiran)

Two doses
a year.^{1†}

Initial year 1 where a booster
dose is required at month 3

Effective and
sustained LDL-C
reduction.^{1†}

^{*} SYBRAVA[®] is dosed initially, again at 3 months,
and then once every 6 months.¹

[†] LDL-C reduction was maintained during each
6-month dosing interval.¹

 **SYBRAVA[®]**
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