February 2022

The Sessional GP

nasgp National Association of Sessional GPs

We are the local community and national voice for GP locums and salaried GPs.

In our 123rd edition, Liz explains the importance of cashflow, Louise has summarised the latest guidance on sleep apnoea and inclisiran, Charles has some great tips on starting out as a locum, and Judith helps us find our voice.

Managing cashflow as a GP locum

TURNOVER IS VANITY, CASHFLOW IS SANITY

By Liz Densley, Speacialist Medical Accountant, Honey Barrett

Work pressures for GPs are continually mounting and finding the time or energy to manage your own finances can seem impossible.

However, if you do not put away funds for tax/NIC/student loan etc as you go, you can end up receiving impossible demands for your money.

In addition, there is the risk of your own ill-health and having to find a way to cope financially with no income.

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And then there is the recent PCSE chaos which rather than simplifying things as promised, makes staying on top of your pension contributions even more tricky.

How to budget

Find a couple of hours to get organised to make it more straightforward going forward and consider:

- How much net income do you need for day to day living?
- What debts do you have? (such as credit cards that aren't paid off in full each month and aren't allowed for in calculation above). What is a reasonable repayment schedule for these?
- How much do you need to save to pay your January and July tax bills?
- How much do you need to save for pension adjustments? Or to pay over monthly amounts that haven't been paid yet?
- How much are you putting away for rainy day savings? (Can you get this balance to equal at least six months' income?)
- How much are you trying to save for specific large purchases (house deposit, new car, home improvements, holidays etc) or to cover a planned career break? What, if any, is left?

Are you clear what income protection you have and what will happen if you are unable to work for an extended period? Speak to an experienced financial adviser to help with this if you need to arrange protection.

You might need to put away up to 50% of your gross freelance income to cover the tax/NIC/student loan repayments. The actual percentage will vary materially depending on whether you have other employment under PAYE or other untaxed income, and whether any of your income falls into the £100k-125k band). Your accountant should be able to help you to calculate an estimate for you, but there may be a charge for this.

Use your cash

If you have a surplus of cash there are lots of options open to you. From an accounting and tax point of view:

Paying off credit card debt or other high interest borrowing is a good initial plan as the interest due is likely to be at a much higher rate than interest you will receive on investments.

Most current accounts pay little or no interest and many savings accounts still pay almost negligible amounts of interest. If you do shop around and manage to secure some interest and the total interest from all sources is less than £500 – for a higher rate taxpayer – it will be tax free.

ISAs are tax free up to the investment limit (£20k in the current year) and these might be worth considering – particularly if you are saving more than immediate needs or if your interest levels are such that you would otherwise pay tax on the interest (look at the interest rates carefully – some are still very low). For stocks and shares ISAs both the dividend income and capital gains are tax free.

Some of my clients swear by Premium Bonds for their tax savings. Income from these is tax free, and yes there is a (tiny) chance of a substantial win, but remember that you don't enter the draw until the month after your investment and unless you have a substantial amount invested you are unlikely to average the advertised rate of return.

Other clients have suggested buying cryptos to save for their tax. This investment is potentially very volatile and not for the faint-hearted. Personally, I wouldn't consider using this for something where I have a definitive £'s payment due for something (any more than I would use foreign currencies or other risky investments). If you have spare funds that you are happy to gamble with, that's a different question – but do your due diligence before risking any of your money.

Protect your savings

On a note of caution, as your savings increase (if only temporarily) remember to try to keep within the £85k per bank to ensure you are fully protected – and be careful to see who has the banking licence as some savings providers share a licence, so the £85k has to be the total between those providers.

If you have savings available for longer term investment, then you need to take advice about how to invest your funds in order to protect yourself against inflation, make use of capital gains exemptions and minimise taxable income. Your accountant will not normally be able to provide direct investment advice – although they can advise on the tax effect of various choices and can discuss recommendations with you.t.

Liz Densley, Honey Barrett

You can now export invoices by date paid on LocumDeck. Last month we reviewed and updated Bookkeeper with advice from specialist medical accountants Honey Barrett. We have now added a new member-requested feature to export invoices and pension details by date paid. Try it yourself today.

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Five tips for starting out as a GP locum

FIVE THINGS THEY DON'T TELL YOU ON VTS

"I decided that this was also a great way to establish relationships with new practices that I could look to work with once my maternity cover came to an end."

By GP locum Dr Charles Elliott

Dr Charles Elliott qualified as a GP in 2020, mid-pandemic, and has gone from the VTS to four- and five-day weeks as a locum after joining the NASGP. He shares his advice for GPs qualifying in 2021 who want to work as GP locums.

1 Ask yourself what is important to you

The first thing you need to ask yourself as a newly-qualified GP is what do you want from work and what your priorities around work are – this will guide how you find your work as a sessional GP.

You may have worked as a trainee in a practice that you feel comfortable in; maybe you are a good fit in that team and feel you would benefit from having the support from a practice that you already know – that's fine. If the

environment is one you can feel comfortable and thrive in then it's a great place to start. You could start your career working as a salaried GP or perhaps a fixed term locum covering maternity, or even by offering additional sessions which CCGs provide 'winter' funding for during periods of high demand – lots of these right now!

Alternatively, you might have a group of practices that you know others in, or that are local to a hospital with referral pathways and community services that you are familiar with – this is also a good way to start after VTS.

Another thing to consider is whether you might be looking to purchase a property or make a financial commitment shortly after completing your training. If this is the case, you might need to consider the intricacies of providing evidence of income to lenders and whether working as a locum allows you to see your plans through in your desired timescale.

At first, I started working six sessions a week providing Locum maternity cover for my training practice as I liked keeping some support and working in a team and system I already knew. Having gone from working five-day weeks, it didn't take long for me to start finding three-day weeks a bit short. I felt that I should be working more during the pandemic and I started looking to find additional work in other practices.

I decided that this was also a great way to establish relationships with new practices that I could look to work with once my maternity cover came to an end.

2 Sign up to LocumDeck

The key part of maintaining a good and stable income as a GP locum is having a good foundation. For me LocumDeck is that foundation.

The inbuilt terms and conditions that practices agree to when booking you act as a form of protection. They ensure that you don't get two weeks' work cancelled at short notice.

LocumDeck also gives you control over how, when and for who you want to work. You can specify what you're willing to do, and what you're going to provide for your fee clearly before the point of booking. Everything is there for practice managers to see and agree to at the time of booking.

For example, per half day session I specify 15 patient contacts including face-to-face, telephone and online consultations. You can even state your desired appointment duration if you like. Practice managers see this information before and after they book me. It gives me great security

knowing that I won't arrive on the day to a 'nightmare' surgery or an unsafe workload with hundreds of pathology results or repeat prescriptions.

LocumDeck also makes the administrative burden of being a GP locum so much easier. It gives practices I have selected access to my GMC registration, performers list status, mandatory training and even my car registration for car parking. It saves me so much time by generating professional invoices with only a few clicks and automatically generates and electronically signs my pension forms.

The instant booking system makes long email trains redundant and something I no longer have to keep up with – it simply makes the booking process painless; just set your availability for the sessions you are willing to work. It also keeps track of my earnings and allows me to download a summary of my income, expenses and pension contributions with a couple of clicks which was perfect for my accountant to use when doing my tax return.

If you're not using it already, give it a go and you'll wonder what to do with your spare time!

3 Link with practices on LocumDeck

Looking for GP locum work earlier in the COVID-19 pandemic was a little tricky with opportunities seeming few and far between as demand on primary care reduced.

When looking for extra sessions, I had to widen my reach and connect with surgeries further afield. I started by linking with practices within the care system I was already working in, given my familiarity with local services and referral pathways. It bought some work but still wasn't reliably giving me 8 sessions a week.

I asked myself, how far am I happy to travel for work? I decided on a 25-mile radius and went through the ever-increasing directory of practices that use LocumDeck and linked myself to all within this radius and that used the clinical system I am most familiar with.

Suddenly, I was linked with 107 practices. It took me a couple of evenings but it was easy to do and soon led to more bookings. Some short notice to cover sickness, others in advance. A few also led to discussions about future longer term locum opportunities.

As the demand in primary care started to rise in the first quarter of 2021, I started getting emails from practices asking if I had availability that I hadn't yet put onto LocumDeck.

4 Listen out for opportunities

I've found that networking and even WhatsApp groups can bring great opportunities. Any time that you hear of potential work opportunities, follow them up and let the practice know your availability.

Even if you can't offer everything they need or are looking for in terms of availability, they may still choose to book you until they find someone else that can help them fully, or separate the work between yourself and another locum. Don't ever write something off if you're interested in the work or the practice. I've found that it's always worth having a conversation.

The most recent opportunity I followed up was a practice looking for a maternity locum for six months. I couldn't do all the sessions they needed, but I still ended up having quite regular work over the last few months with them. I also spoke to a partner about a salaried job recently, and whilst it wasn't the right opportunity for me right now, they ended up saying, 'Oh, well, we'll get you in for a couple of locum sessions' which was great to see whether this could be a good practice for me in the future.

Keep networking as much as you can. Having recently completed training, I am already on WhatsApp groups with my trainees. I also joined the RCGP's First Five in the neighbouring patch. Every so often through these networks, I hear of a practice looking for locum cover for the next two weeks, or looking for a maternity cover – something I can help with. I keep the groups muted, but they have been a good source of work and often come from colleagues with a recommendation about the culture in the practice which is always nice to have before working somewhere. They are also great groups to support one another with clinical queries or dilemmas and wellbeing tips.

5 Get new practices on board

When I wanted to explore an opportunity to work with a practice that wasn't yet registered with LocumDeck, I dropped them an email saying, 'Hi, I've heard that you're looking for some cover, here's my CV, let me know if I can help'.

They normally end up ringing me up and saying, 'Right, when can you come?' and at this point I tell them: 'I have some availability over the next couple of weeks, but I do all my booking through LocumDeck where you can see my availability and book me in real-time.' Initially they sometimes groan and think it sounds complicated, but telling them about all my compliance documents being in one place usually helps. I then I follow up with an email with a link to the practice signup page for LocumDeck, so that

they can sign up to it and once they have done so, I link with the practice and click the slider so that they can instant book me.

Sometimes you do have to repeat yourself a few times. There was one practice that I ended up asking to join LocumDeck on the phone twice and then in about three emails – but they did it in the end. What pushed them to prioritise registering and booking on LocumDeck was that I put my availability on for only their practice to see and said, 'I have put my availability on LocumDeck so that it's reserved for your surgery until Thursday night. And then I will have to open availability up to other practices.' By giving them a timeframe – I usually go for three or four days – it forces them to make a decision either way and I found that most book within a couple of hours.

It might sound stubborn, but the security that LocumDeck brings with the comprehensive terms and conditions, and clarity around the workload I am willing to undertake isn't there if I agree to a booking via email. It is when practices book through LocumDeck.

This is what makes LocumDeck such a powerful tool. It gives me confidence knowing that I'm not going to get inundated with an unsafe surgery or workload. The practice has read everything and everyone is on the same page. On the rare occasion that a practice doesn't stick to the agreed terms then it's easy for me to point this out and any issues get rectified quickly, without any hassle.

Dr Elliott is a GP locum and the lead for NASGP's Frimley Locum Chambers.

image © Claire de Mortimer - website

Chronic sleep apnoea

CAN BE LARGELY MANAGED BY TREATING UNDERLYING CONDITIONS

"Rhinitis can worsen sleep quality so we should treat it in patients with OHAHS. It can also affect a person's ability to tolerate CPAP."

Summary from NASGP member Dr Louise Hudman.

This is a new guideline from NICE on the three different sleep apnoea syndromes, published in August 2021.

They cover three different syndromes in this guideline:

- OSAHS – Obstructive sleep apnoea/hypopnoea syndrome.
- OHS – Obesity hypoventilation syndrome.
- COPD-OSAHS overlap syndrome – COPD with OSAHS.

Useful resources

NICE has produced a useful visual summary on the assessment of these three syndromes. This is an excellent resource and covers most of what we need to know.

There is DVLA guidance on driving with OSAHS.

What is different for GPs in this guideline?

- There is a long list of conditions that come with a higher prevalence of OHAHS. I found some of them surprising, like Down's syndrome or moderate to severe asthma.
- Alongside the Epworth Scale, we should consider using the STOP-Bang Questionnaire for people with OHAHS or COPD-OHAHS. See below for more details on this.
- Some people will need a more rapid assessment, for example those that drive for a living or work in particular occupations (eg surgeons).
- All patients need advice on smoking, weight management, alcohol and sleep hygiene.
- Rhinitis should be assessed for and treated in people with OHAHS or OHS. It can make sleep worse and can also affect how well people tolerate CPAP.

What is the pathology in these three different sleep syndromes?

- In OHAHS the upper airways narrow or close during sleep when the muscles relax. This leads to apnoea or hypopnoea. The patient then either wakes up, or lightens their sleep. This leads to disturbed sleep and then can lead to excessive daytime sleepiness.
- In OHS (obesity hypoventilation syndrome), patients will have a BMI of 30 or more. They also have a raised arterial CO2 level when awake and breathing disturbance at night. This can either be an obstructive apnoea or hypopnoea or they can have hypoventilation or combinations of these three. OHS is a form of ventilatory failure.
- In COPD-OHAHS they have both conditions. The combination of the 2 conditions leads to a greater morbidity that either would have alone.

What conditions have a higher prevalence of OHAHS?

The following conditions have a higher prevalence of OHAHS:

- obesity or overweight
- obesity or overweight in pregnancy
- treatment-resistant hypertension
- type 2 diabetes
- cardiac arrhythmia, particularly atrial fibrillation
- stroke or transient ischaemic attack
- chronic heart failure
- moderate or severe asthma
- polycystic ovary syndrome
- Down's syndrome
- non-arteritic anterior ischaemic optic neuropathy (sudden loss of vision in 1 eye due to decreased blood flow to the optic nerve)
- hypothyroidism

What are the features of OHAHS?

Assess for OSAHS if people have two or more of the following:

- Snoring.
- Witnessed apnoeas.
- Unrefreshing sleep.
- Waking headaches.
- Unexplained excessive sleepiness, tiredness or fatigue.
- Nocturia (waking from sleep to urinate).
- Choking during sleep.
- Sleep fragmentation or insomnia.
- Cognitive dysfunction or memory impairment.

What features do people with OHS and COPD-OHAHS have?

A BMI of 30 or more (for OHS) or COPD (for COPD-OHAHS, plus:

- Features of OHAHS, or features of nocturnal hypoventilation such as:
    - Waking headaches.
    - Peripheral oedema.

- Hypoxaemia (arterial oxygen saturation less than 94% on air).
- Unexplained polycythaemia.

What assessment scales should you use for sleep apnoea?

- Do the Epworth sleepiness scale for all three conditions. Do not use it to determine if referral is needed as not all patients will have excessive sleepiness. It isn't great for either sensitivity of specificity and there is limited evidence for its use. You do need it for the DVLA though and many areas require it for referral.
- Consider using the STOP-Bang Questionnaire for OHAHS and COPD-OHAHS as well. Limited evidence suggests good sensitivity, but low specificity. It may underestimate the risk in people with certain conditions and in women. It does look at risk as well as symptoms which may be helpful.

What should you include in your referral?

There is specific information that should be included in the referral:

- Results of the person's assessment scores.
- How sleepiness affects the person.
- Comorbidities.
- Occupational risk.
- Oxygen saturation and blood gas values, if available.

For a patient with OHS, include:

- BMI.
- Any history of emergency admissions and acute non-invasive ventilation.

For a patient with COPD-OHAHS, include:

- BMI.
- Severity and frequency of exacerbations of COPD.
- Use of oxygen therapy at home.
- Any history of acute non-invasive ventilation.

What factors may mean that someone needs a more rapid assessment?

The following features would require a more rapid assessment:

- They have a vocational driving job.
- They have a job for which vigilance is critical for safety (eg surgeon, but there is a list of such jobs in the guideline in the 'why the committee made this decision box').
- They have unstable cardiovascular disease, for example, poorly controlled arrhythmia, nocturnal angina or treatment-resistant hypertension (OSAHS is a risk factor for these).
- They are pregnant (OSAHS is associated with worse maternal and baby outcomes).
- They are undergoing preoperative assessment for major surgery (so as to avoid delay to surgery).
- They have non-arteritic anterior ischaemic optic neuropathy (possible association with OSAHS and sudden blindness in this condition).

In OHS or COPD-OHAHS, what additional factors would require a more rapid assessment?

The following features would require a more rapid assessment:

- They have severe hypercapnia (PaCO2over 7.0 kPa when awake). These patients have a higher risk of respiratory failure.
- They have hypoxaemia (arterial oxygen saturation less than 94% on air). These patients have a higher risk of respiratory failure.
- They have acute ventilatory failure.

What lifestyle advice should we give all apnoea patients?

- Stop smoking. Smoking causes upper airway inflammation which can exacerbate symptoms.
- Prevent excess weight gain (eg stay a healthy weight).
- Obesity. Obesity increases the prevalence of OHASH/OHS and its severity.
- Alcohol. Excess alcohol before sleep reduces muscle tone and reduces sleep quality.

- Sleep hygiene. Advice on sleep hygiene may include ensuring adequate sleep time, avoiding caffeine and stimulants that interfere with sleep before bedtime, exercising regularly, having a quiet, comfortable, darkened bedroom and winding down before sleep.

Do all apnoea patients need treatment?

No. If a patient has isolated mild OHAHS with no daytime sleepiness, or sleepiness that doesn't affect their usual activities, then treatment is not normally required. Lifestyle advice alone maybe all that is required.

Patients with the following need treatment:

- Mild OHAHS with symptoms affecting their quality of life or their usual daytime activities.
- Moderate or severe OHAHS.
- All patients with OHS.
- All patients with COPD-OHAHS.

What treatments are used?

The mainstay of treatment is:

- CPAP.
- Non-invasive ventilation.

What is the importance of rhinitis in patients with OHAHS?

Rhinitis can worsen sleep quality so we should treat it in patients with OHAHS. It can also affect a person's ability to tolerate CPAP.

What are the current DVLA rules on OHAHS, OHS and COPD-OHAHS?

The DVLA uses the umbrella term of obstructive sleep apnoea syndrome.

Its current guidelines advise that:

- Excessive sleepiness including mild obstructive sleep apnoea syndrome. Patients must not drive. Driving may resume only after satisfactory symptom control. If symptom control can't be achieved within three months, then the DVLA must be notified.

- Excessive sleepiness due to moderate to severe obstructive sleep apnoea syndrome. Patients must not drive. Patients must notify the DVLA.
- Excessive sleepiness due to suspected obstructive sleep apnoea syndrome Patients must not drive. Driving may resume only after satisfactory symptom control. If symptom control can't be achieved within three months, then the DVLA must be notified.

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Who's speaking

THE WAY WE SPEAK HELPS DEFINE WHO WE ARE.

"You may not propose marriage to Alexa but she's 'human' enough that saying hullo to her is almost a reflex."

By NASGP member Judith Harvey

Remember Billroth I and II? But Theodore Billroth's wasn't just a pioneering gastric surgeon. He successfully performed the first total laryngectomy in 1873. He was also a talented musician and a friend of Johannes Brahms, who sought his opinion on his latest compositions.

Soprano Gweneth-Ann Rand knows what it's like to face voice-threatening throat surgery. Fortunately, the operation on her throat tumour left her vocal cords intact. At a concert she gave last May, after the applause, we in the

audience were asked to stay in our seats for a surprise. A woman called Sara came on stage. She put her finger over her laryngectomy stoma and she and Rand sang Sara's poem 'Can you Hear my Voice?', set to music by composer Hannah Conway. Sara felt she not only lost her voice, she lost part of her identity. Could she still express herself? Was she the same person?

Romantic lead? Screen villain? Our voices tell others so much about us. How do we respond to changed voices? To artificial voices? Do you swear at your satnav? Are you irritated by Alexa? Standing on the station platform, how much confidence do you have in loudspeaker announcements?

The BBC R&D unit is creating a library of all the sounds of normal speech. That isn't straightforward. Give any non-professional a passage to read and it won't sound genuine. Every patient we see has different 'normal speech'. So, thousands of sounds must be fed into the sophisticated computer programme which generates an infinite number of words and sentences.

These synthetic voices are then tried out on the public. Disembodied artificial voices can arouse strong emotions, just as real voices do. You may not propose marriage to Alexa but she's 'human' enough that saying hullo to her is almost a reflex. Though she can be very trying. Would we find computer-generated voices less irritating if they were more human? Or less?

What voices do we feel are appropriate for what use? An announcement of a plane crash on national news demands a different tone from a local radio station listing local garden fetes. And would an artificial voice with the same honest Scots accent seem equally trustworthy?

Our identity is our voice. It tells others a lot about us, though not always exactly who we are. When my sister and I shared a flat our father could never tell us apart on the phone and would fish for clues while we teased him.

We adjust to changed strange voices, even synthetic ones. When Stephen Hawking was offered a more lifelike voice he opted to retain the one he had used for years; however unnatural, it had become 'his' voice.

As we age the pitch of our voice drops. Our delivery slows and becomes breathy because the muscles which close our vocal cords are weaker. Watch one of David Attenborough's recent programmes. They include clips from programmes he made years ago. Compare his 95-year-old's voice with his younger self. Or compare the Queen's Christmas broadcasts over the years.

But a laryngectomy is different. How do you rebuild your life? The post-op therapists may enable you to produce some sort of voice, fellow-sufferers will share experience and tips, but when speech is a struggle it's hard to process the burden of loss.

Shout At Cancer, founded by Dr Thomas Moors, uses singing and acting and ultimately public performance to restore not just the voice but also the confidence that laryngectomy takes away.

Hannah Conway's Sound Voice investigates voice, its role in our identity and the experience of losing it. She describes it as 'opera meets biomedical research'. People who live with voice loss, and their families, come together with musicians, therapists, medics, scientists and engineers working on re-creating larynxes. Sound Voice has created an intriguing 25-minute video installation which presents an audio-visual of performances by Paul, Tanja and a Shout at Cancer choir.*

Paul, who has motor neurone disease, says he felt like a monk who had taken a vow of silence until he stood on stage and sang with baritone Roderick Williams. He extended Paul's struggling words and gave them operatic fluency.

Tanja only had a week to prepare for her laryngectomy, so she made a video for her small children. She knows she will sound different. She won't be able to chat with them while she is eating, sing to them or laugh, or call out the moment they appear to be in danger. In their duet, soprano Lucy Crowe projects these anxieties, while Tanja's new voice sings that she is still mummy and loves her kids as much as she ever did.

There are choirs throughout the country for people with any condition which weakens the strength of the voice. If you have Parkinson's Disease how much easier it must be to initiate voluntary movements when you are singing with others. And how much pleasure it must give.

I cannot forget the first patient I saw when I started my first house-job. He was dying of throat cancer. His trachy filled up with mucus, he was very weak and he couldn't speak, but his overwhelming fear was obvious. I felt powerless to help him. Most of the 35,000 new head and neck cancer diagnoses per year in UK are laryngeal cancers, and the incidence has increased by a third in the last 25 years, more in women, and deprivation is a risk factor. It isn't just the patients who have to come to terms with voice loss; it's a challenge for all of us.

** Hannah Conway hopes that galleries and public spaces and healthcare settings will use the Sound Voice's installation to stimulate interest and more understanding of what it means to lose your voice. For more information see soundvoice.org.*

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Inclisiran for lipid modification

A NEW INJECTION TO BE INITIATED IN GENERAL PRACTICE.

"Inclisiran can be used in people with primary hypercholesterolaemia (both heterozygous familial and non-familial) and in people with mixed dyslipidaemia."

Summary from NASGP member Dr Louise Hudman.

NICE has released new guidance on the use of inclisiran (Leqvio) for lipid modification, published last October. You have probably already heard about this as it was widely reported in the news.

Why is inclisiran important for GPs?

It's a new drug and is likely to be started and continued in primary care. It looks like it will start being widely used from 2022.

How does inclisiran work?

It is a small interfering ribonucleic acid (siRNA). It gets taken up into hepatocytes and causes increased recycling and expression of LDL-C receptors on the hepatocyte cell surface. This leads to increased LDL-C uptake and lower levels in the circulation.

How is inclisiran given?

It is a subcutaneous injection. It is given at initiation, then at three months, then six-monthly thereafter.

When can GPs use inclisiran?

Inclisiran can be used in people with primary hypercholesterolaemia (both heterozygous familial and non-familial) and in people with mixed dyslipidaemia.

It can only be used for secondary prevention (eg after ACS, coronary or other arterial revascularisation, CHD, ischaemic stroke or PAD). It can not be used for primary prevention at present as it isn't cost-effective enough.

It can only be used if the LDL-C (LDL cholesterol) is persistently ≥ 2.6, despite maximally tolerated lipid-lowering therapy (either a statin with or without other drugs, or other drugs if statins can't be used).

Is inclisiran effective?

Yes it is. It works when other drugs haven't adequately controlled LDL-C. However, there is no long term evidence that it reduces cardiovascular events. There isn't any evidence that it doesn't, it's just that the studies haven't been long enough to see any evidence on any reduction in cardiovascular events yet.

There haven't been any direct comparisons between Inclisiran and ezetimibe, alirocumab or evolocumab yet.

Want to read more about lipid modification? I have done a recent overview of lipid modification which covers when to use statins and other lipid modifying drugs.

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