Dépistage de l'ischémie myocardique

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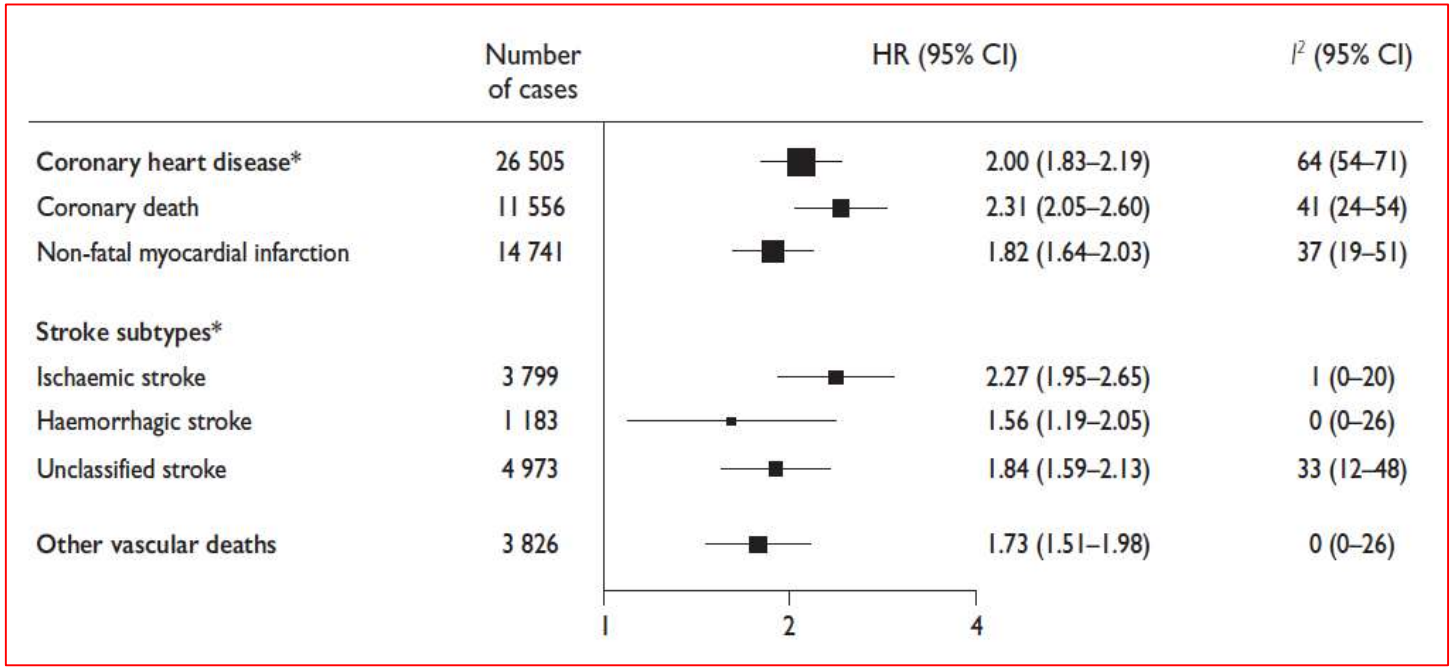
1

DEPISTAGE DE LA CARDIOPATHIE ISCHEMIQUE CHEZ LE PATIENT DIABETIQUE

Epidémiologie

- Diabétiques en France: 5.1 millions de patients (9%)
- Un risque X2 de décès cardiovasculaire
- Ischémie silencieuse fréquente liée à une dysfonction endothéliale et dysfonction du système nerveux autonome



	Number of cases	HR (95% CI)	I^2 (95% CI)
Coronary heart disease*	26 505	2.00 (1.83–2.19)	64 (54–71)
Coronary death	11 556	2.31 (2.05–2.60)	41 (24–54)
Non-fatal myocardial infarction	14 741	1.82 (1.64–2.03)	37 (19–51)
Stroke subtypes*			
Ischaemic stroke	3 799	2.27 (1.95–2.65)	1 (0–20)
Haemorrhagic stroke	1 183	1.56 (1.19–2.05)	0 (0–26)
Unclassified stroke	4 973	1.84 (1.59–2.13)	33 (12–48)
Other vascular deaths	3 826	1.73 (1.51–1.98)	0 (0–26)

Vs. Non diabétiques (étude cohorte de 530 083 patients)

Sawar et al, Lancet 2010

Stratifier le niveau de risque CV

Very high CV risk	Patients with T2DM with: • Clinically established ASCVD or • Severe TOD or • 10-year CVD risk ≥20% using SCORE2-Diabetes
High CV risk	Patients with T2DM not fulfilling the very high-risk criteria and a: • 10-year CVD risk 10 to <20% using SCORE2-Diabetes
Moderate CV risk	Patients with T2DM not fulfilling the very high-risk criteria and a: • 10-year CVD risk 5 to <10% using SCORE2-Diabetes
Low CV risk	Patients with T2DM not fulfilling the very high-risk criteria and a: • 10-year CVD risk <5% using SCORE2-Diabetes

https://www.guideline.care/score/calculateur-score2-diabetes

- Pays, âge, sexe,
- Ancienneté du diabète, tabac
- Hba1%, TAS, Cholestérol, DFG

Severe TOD:

- **eGFR <45 mL/min/1.73 m2**
- **eGFR 45–59 mL/min/1.73 m2** + microalbuminuria (rapport albuminurie/creatinine= 30–300 mg/g);
- **Proteinuria** (rapport albuminurie/creatinine= >300 mg/g; stage A3),
- **Microvascular disease in at least 3 different sites** [e.g. microalbuminuria (stage A2) + retinopathy + neuropathy]

Recommandations sur le dépistage du diabète

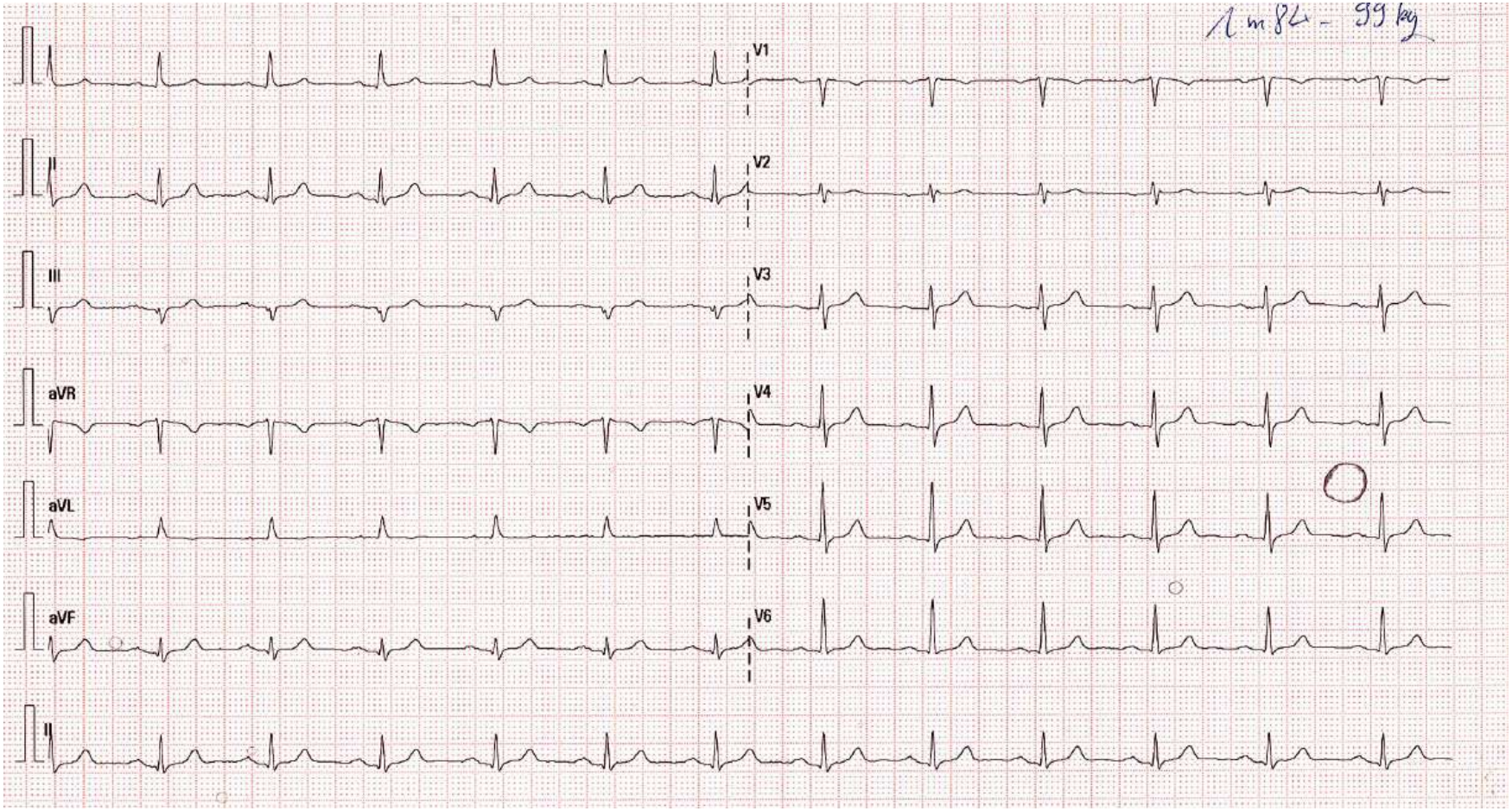
Recommendations	Class[a]	Level[b]
Screening for diabetes is recommended in all individuals with CVD,[c] using fasting glucose and/or HbA1c.[5–7,36,37,39]	I	A
It is recommended that the diagnosis of diabetes is based on HbA1c and/or fasting plasma glucose, or on an OGTT if still in doubt.[d,5–8,10,11]	I	B

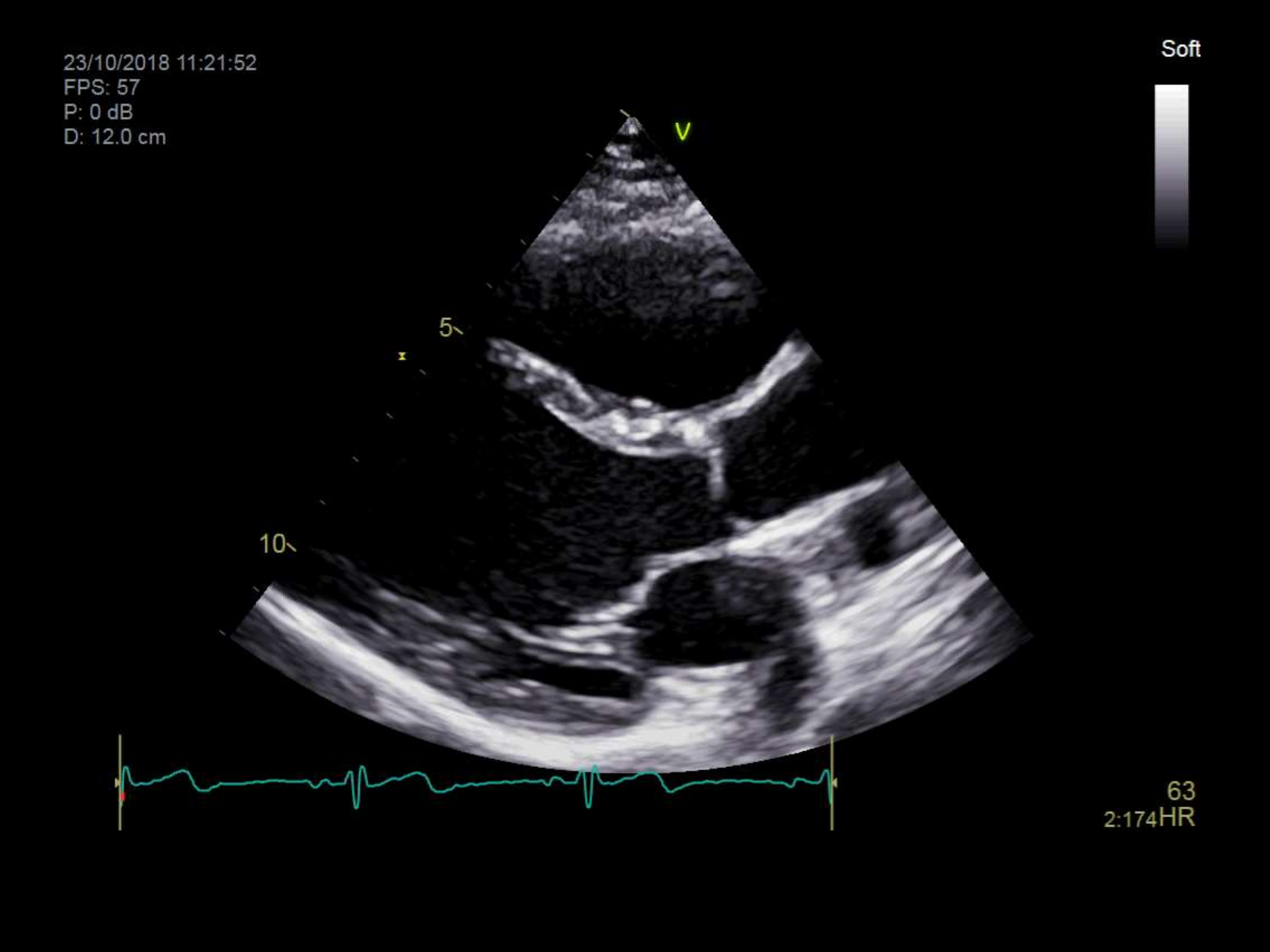
- **Diabète si HbA1c ≥48 mmol/mol (≥6.5%)**
- **Pre-diabetes si HbA1c 42–47 mmol/ mol (6.0–6.4%)**

Cas Clinique n°1

- Un homme de 50 ans diabétique depuis 10 ans vous est adressé pour une évaluation cardiovasculaire. Il ne présente pas d'antécédent cardiovasculaire notable. A l'interrogatoire, il est asymptomatique. Sa pression artérielle systolique est à 150/90mmHg, sa FC à 85 bpm. Il pèse 99Kg pour une taille 1,84m. Son traitement comporte diamicron. Son HbA1 est à 8%, sa créatinémie est à 60microM/L et il n'y a pas de protéinurie dans les urines. Son LDL cholestérol est à 1,4g/L

Cas clinique

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D: 12.0 cm
Soft
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5
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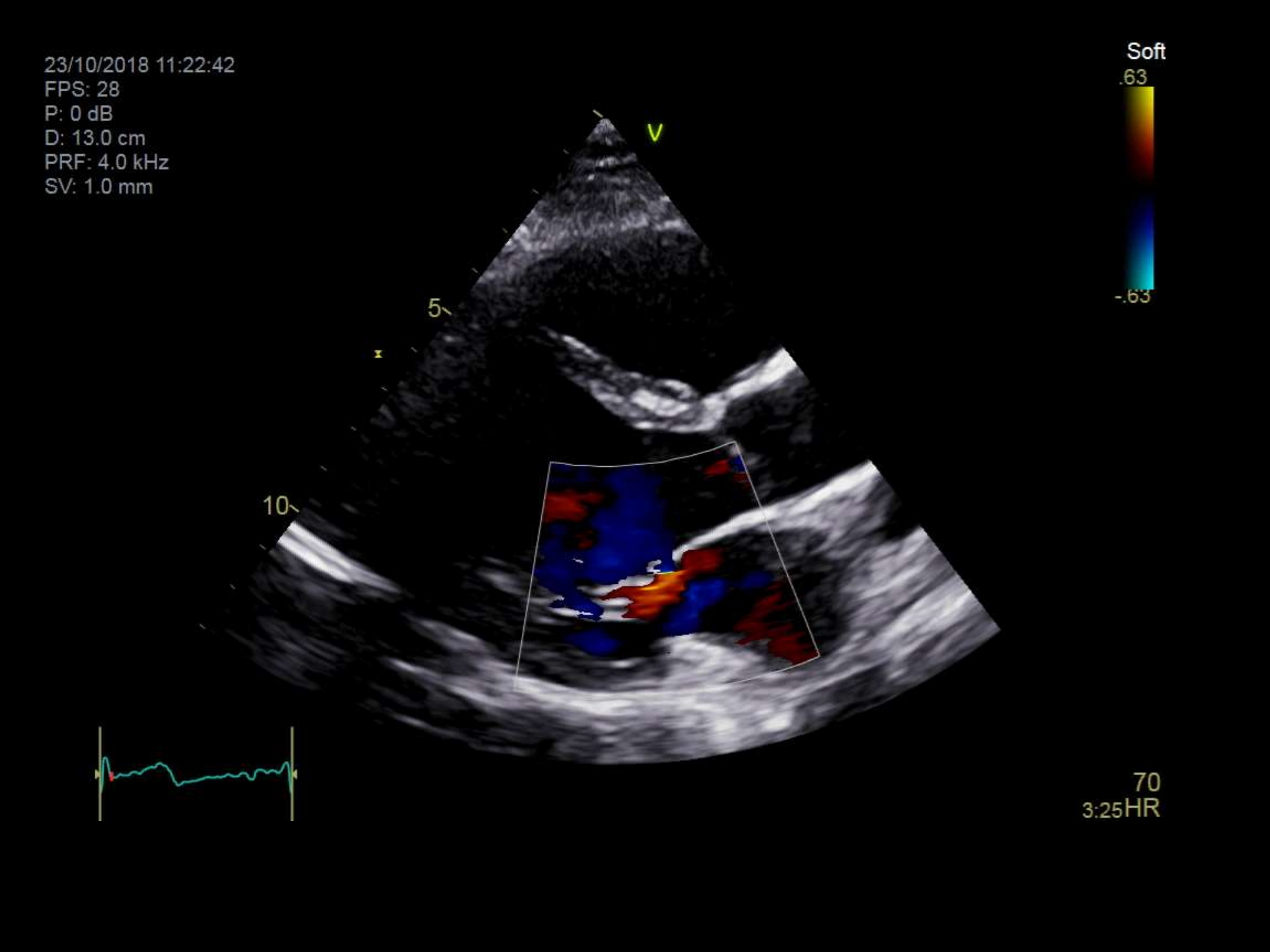
2:174HR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.63
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5
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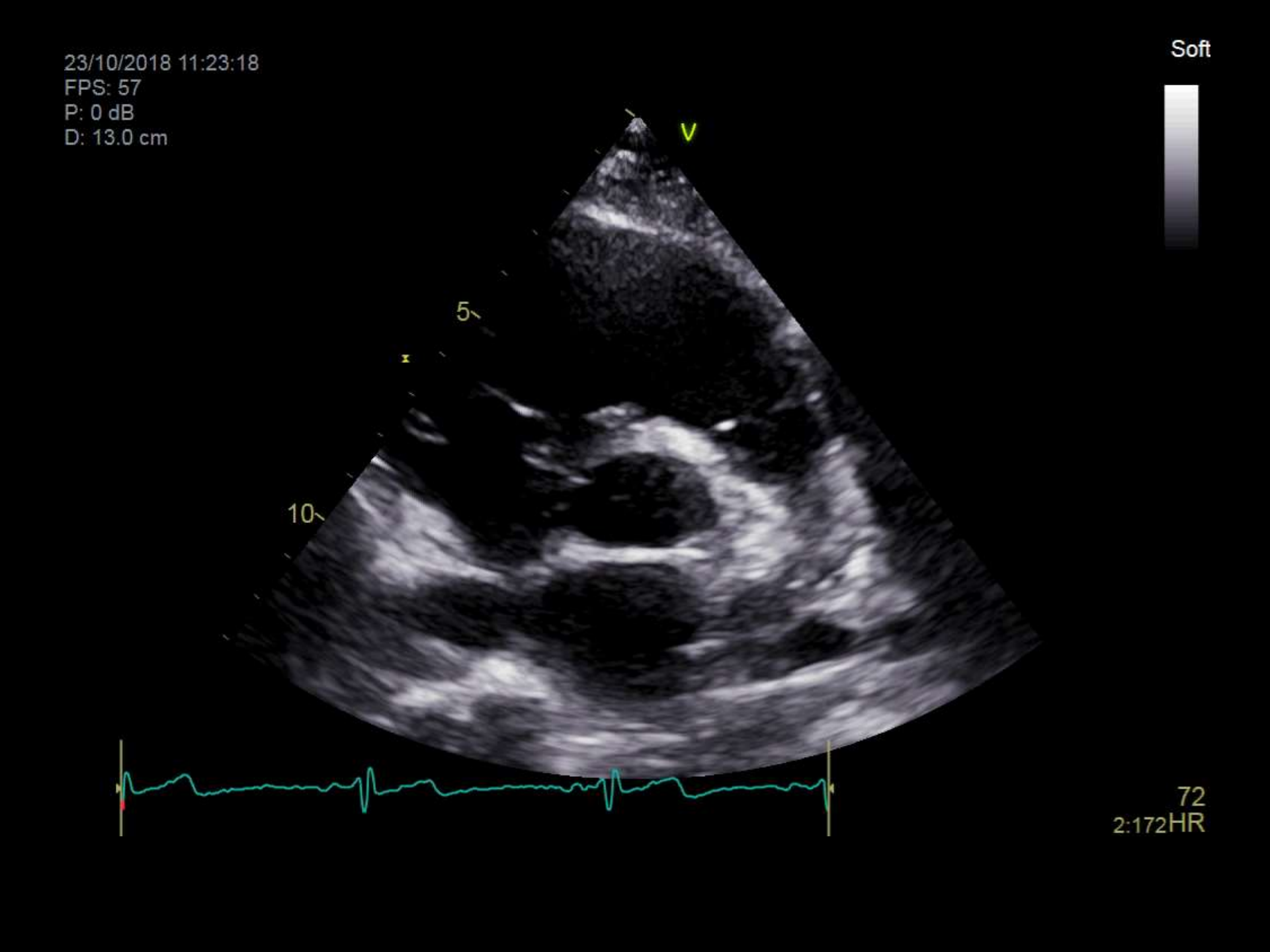
70
3:25HR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72
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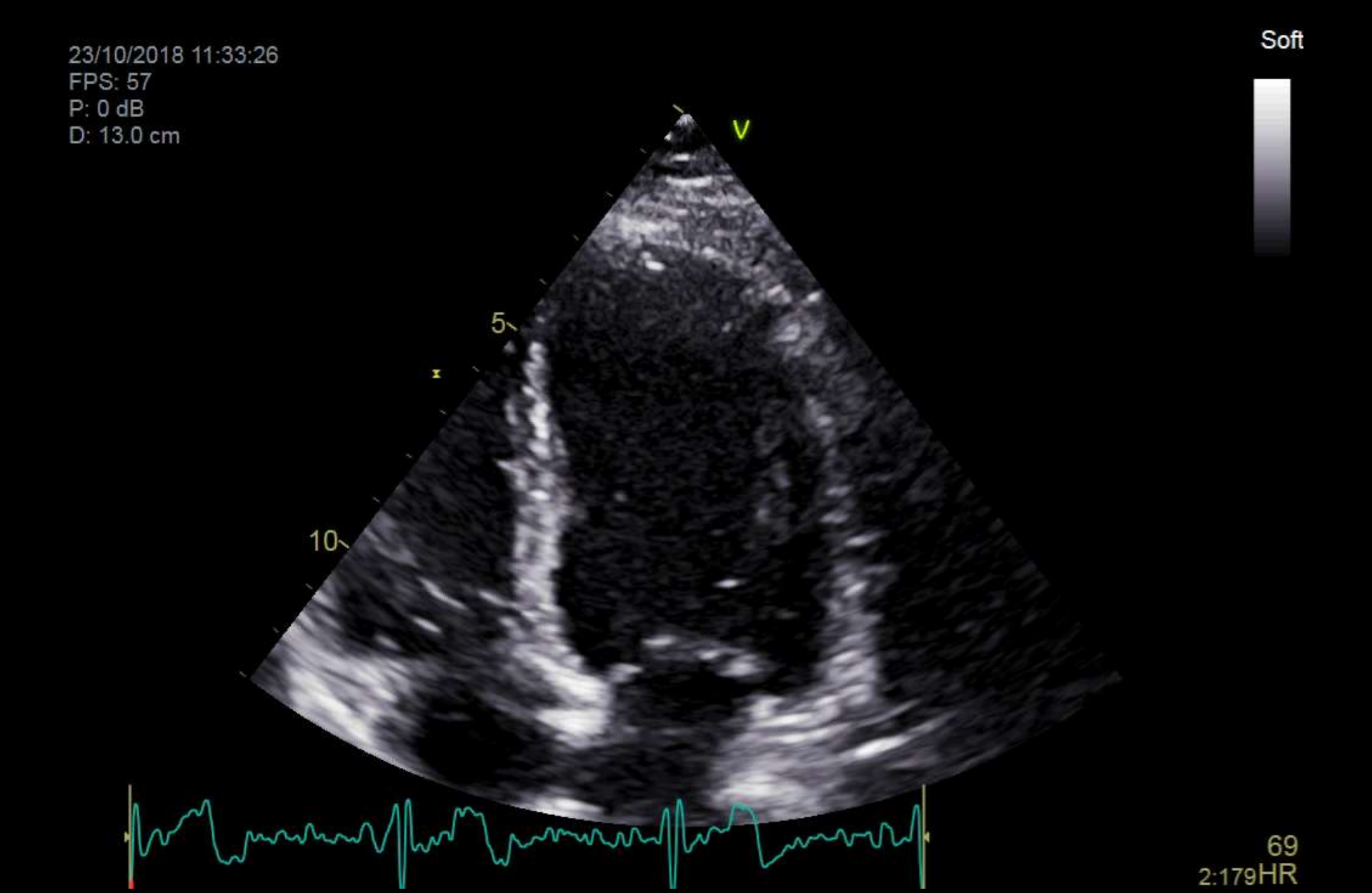
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Soft
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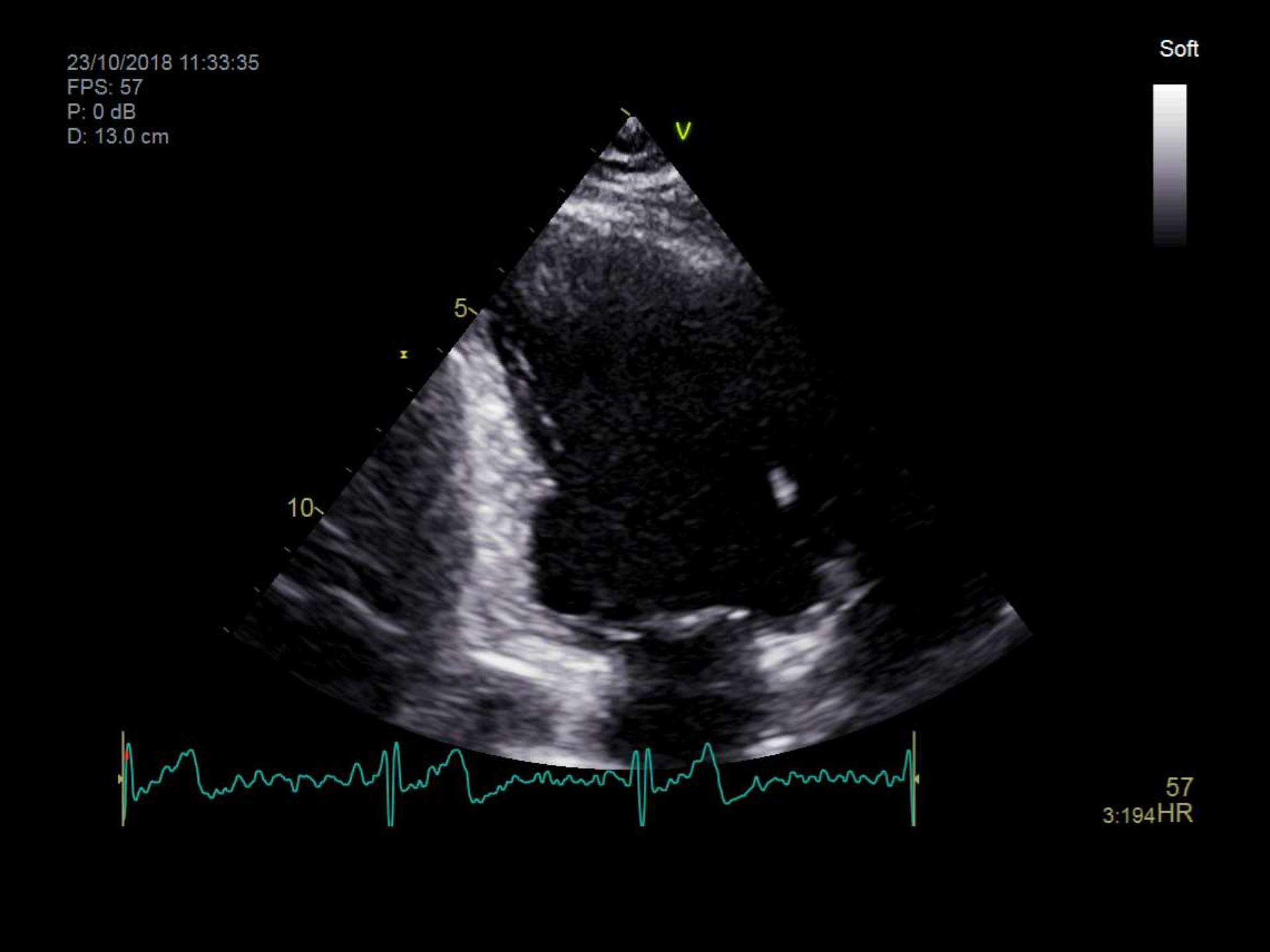
10
69
2:179HR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Soft
V
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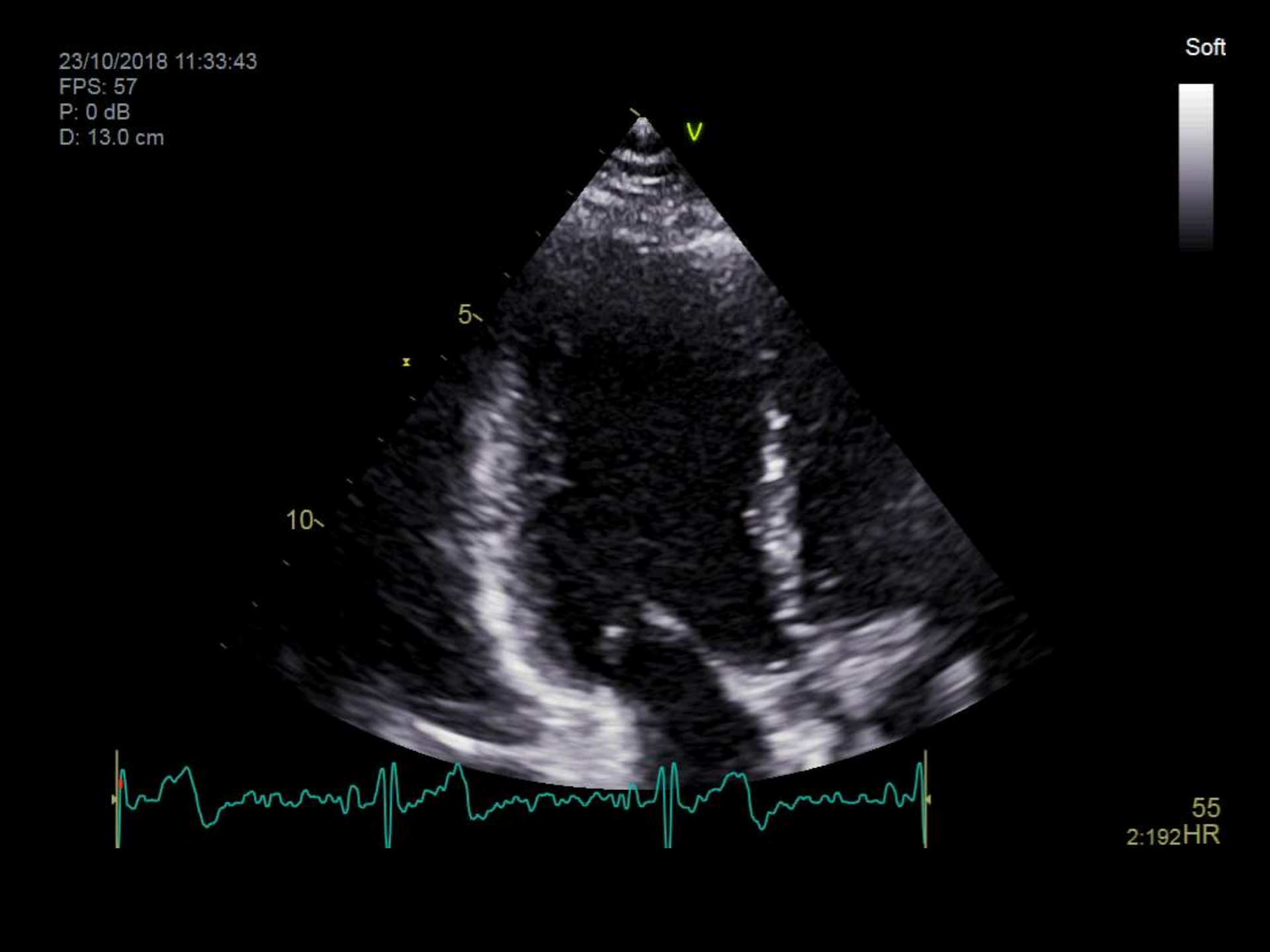
10
57
3:194HR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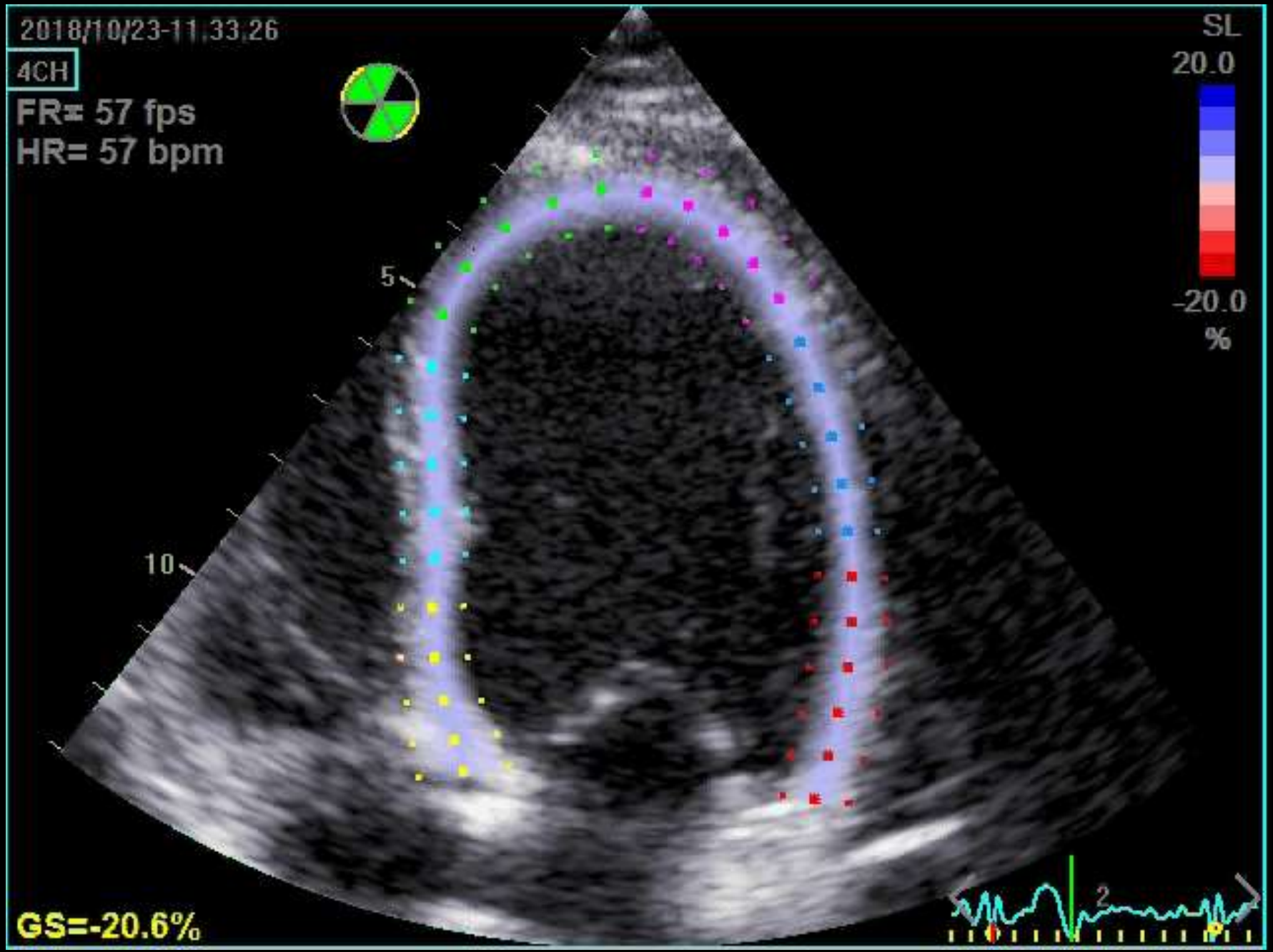
D: 13.0 cm
Soft
V
5
10
55
2:192HR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4CH
FR= 57 fps
HR= 57 bpm
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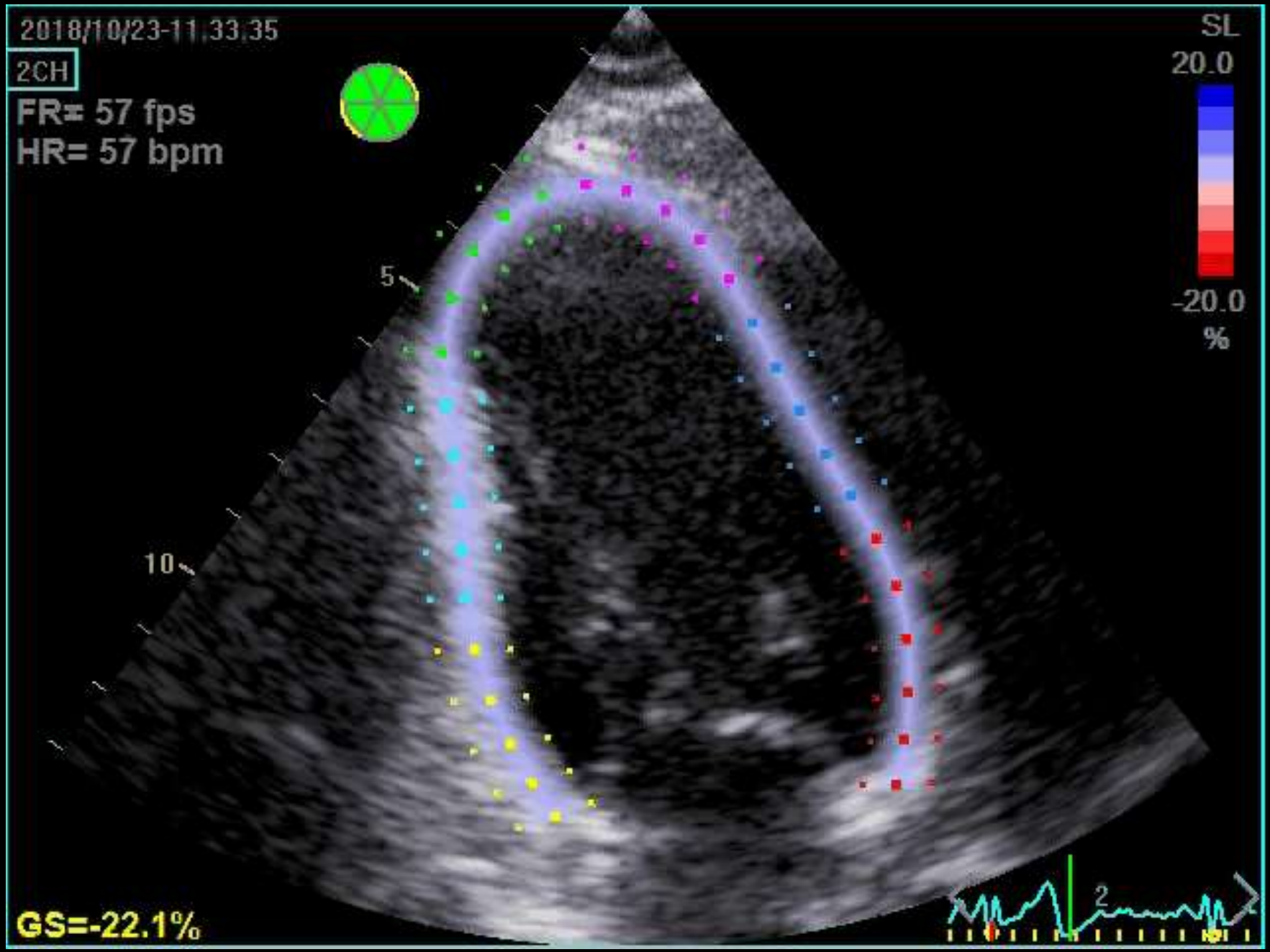
%
5
10
GS=-20.6%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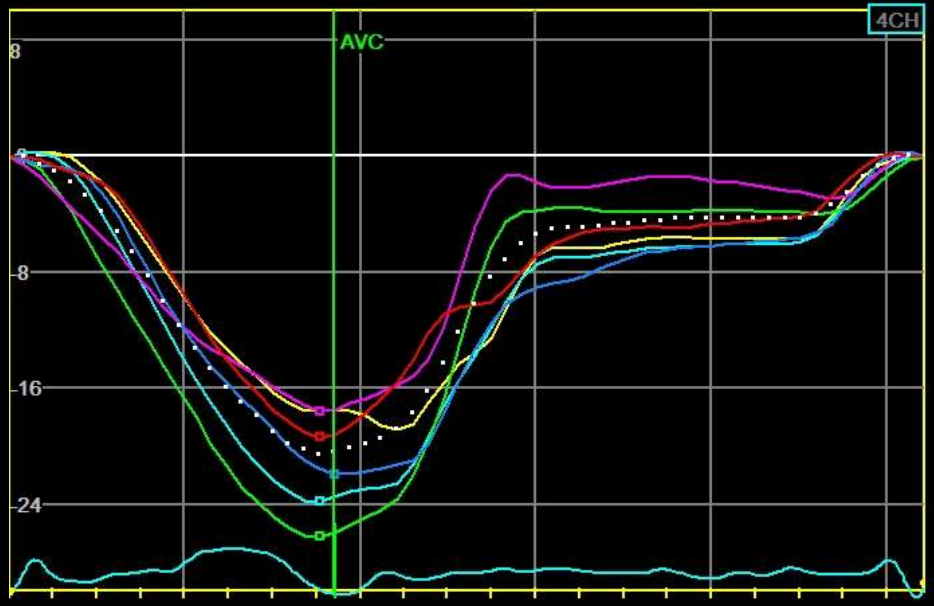
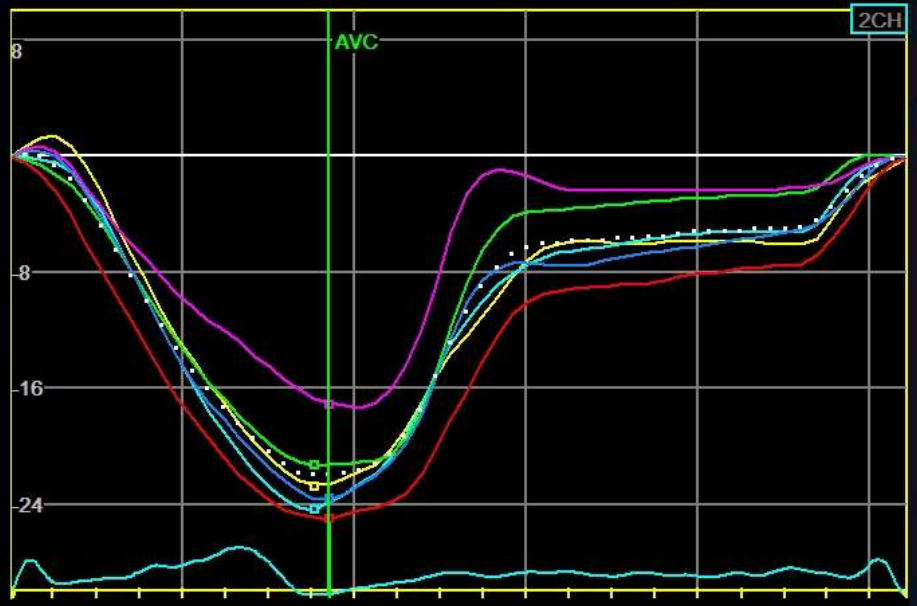
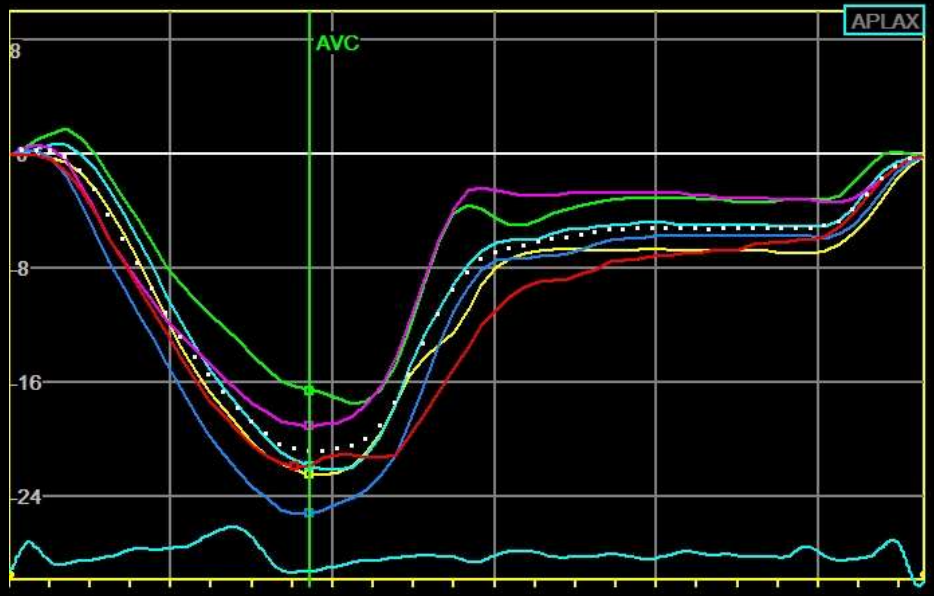
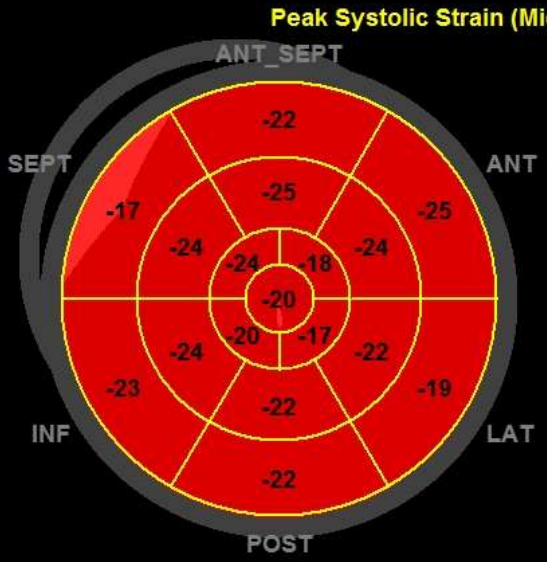
GS=-22.1%









GLPS_LAX -20.9 %
GLPS_A4C -20.6 %
GLPS_A2C -22.1 %
GLPS_Avg -21.2 %
AVC_AUTO = 371 msec
FR_min = 57
HR_aplax = 53
PSD = 28 msec

24/10/2018-11:43:55

Question

- **Quelle exploration proposez vous à ce patient?**
  - **un scanner coronaire**
  - **une épreuve d ’effort**
  - **une échographie d’effort**
  - **Aucune**

2 Les grandes études

Cardiac Outcomes After Screening for Asymptomatic Coronary Artery Disease in Patients With Type 2 Diabetes

The DIAD Study: A Randomized Controlled Trial

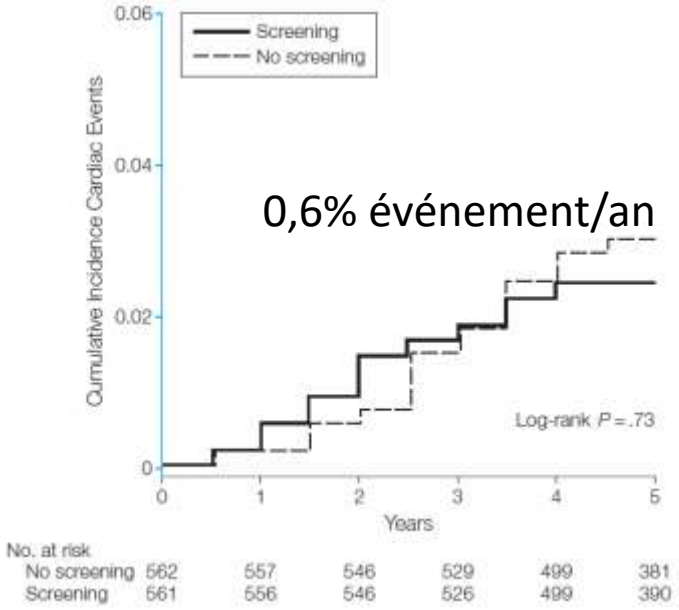
	No Screening (n = 562)	Screening (n = 561)
	Mean (SD)	
Age, y	60.8 (6.4)	60.7 (6.7)
Diabetes duration, y	8.9 (6.9)	8.2 (7.1)
Body mass index[a]	31.0 (6.1)	31.1 (6.5)
Hemoglobin A_{1C}, %	7.0 (1.5)	7.2 (1.6)

L'étude DIAD est la plus grande étude randomisée évaluant le screening de l'ischémie silencieuse par scintigraphie chez le patient diabétique asymptomatique

Young LH et al. JAMA **2009**

Cardiac Outcomes After Screening for Asymptomatic Coronary Artery Disease in Patients With Type 2 Diabetes

The DIAD Study: A Randomized Controlled Trial



0,6% événement/an

	No. (%) of Patients		
	No Screening (n = 562)	Screening (n = 561)	Log-Rank *P* Value[b]
Primary events	17 (3.0)	15 (2.7)	.73
Myocardial infarction	10 (1.7)	7 (1.3)	.66
Cardiac death	7 (1.2)	8 (1.4)	.80
Secondary events	14 (2.5)[c]	21 (3.7)	.23
Unstable angina	3 (0.5)	4 (0.7)	.70
Heart failure	7 (1.2)	7 (1.2)	.99
Stroke	5 (0.9)	10 (1.8)	.20
Revascularizations	44 (7.8)[d]	31 (5.5)	.14
PTCA	27 (4.8)	15 (2.7)	.74
CABG surgery	20 (3.6)	16 (2.9)	.76
Death			
All cause	15 (2.7)	18 (3.2)	.60
Noncardiac	8 (1.4)	10 (1.8)	.63

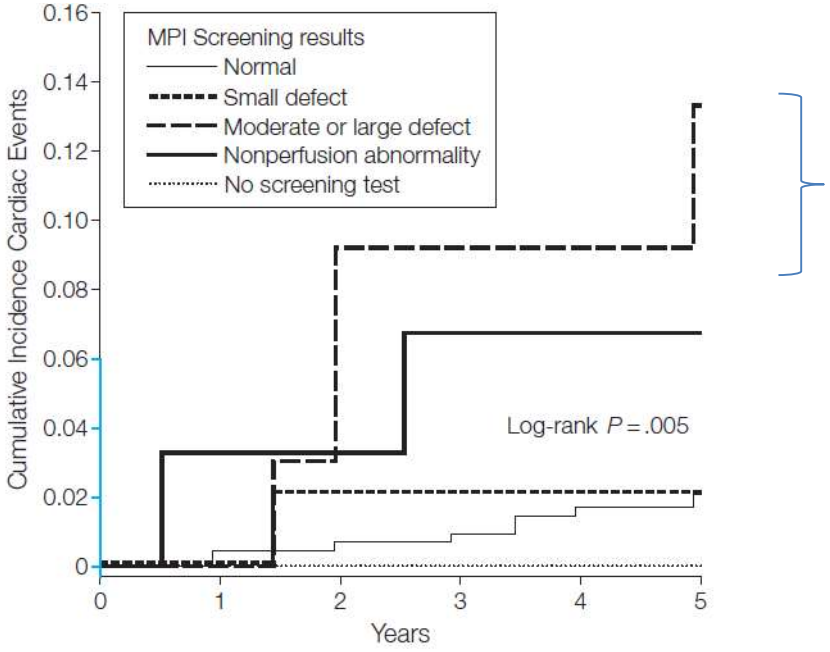
Elle montre que le **taux d'événement e**st relativement faible

P**as de bénéfice à réaliser un dépistage** par scintigraphie chez le patient diabétique asymptomatique

Young LH et al. JAMA **2009**

Cardiac Outcomes After Screening for Asymptomatic Coronary Artery Disease in Patients With Type 2 Diabetes

The DIAD Study: A Randomized Controlled Trial



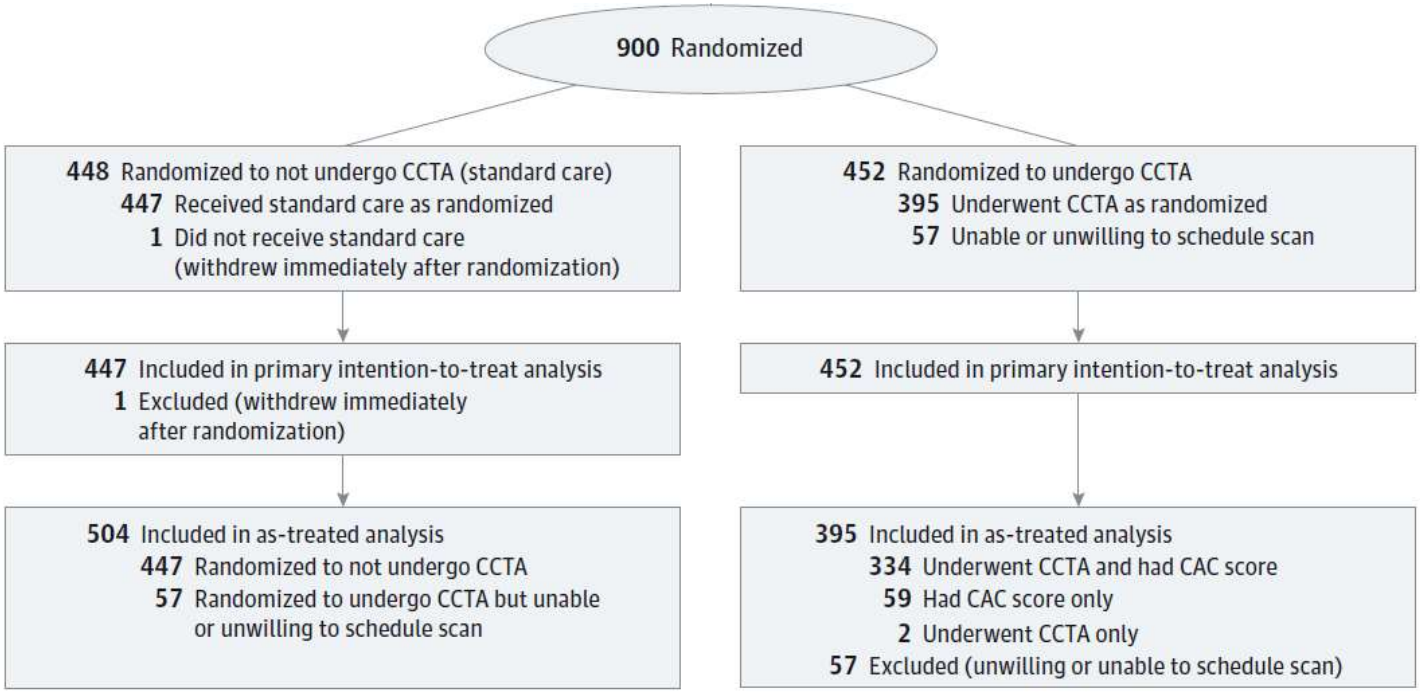
No. at risk MPI Screening results						
Normal	409	408	402	389	370	290
Small defect	50	49	48	46	42	32
Moderate or large defect	33	33	32	30	29	22
Nonperfusion abnormality	30	29	29	27	26	20
No screening test	39	37	35	35	34	26

Anomalies de perfusion
Ou défaut de perfusion
moyenne ou large

Néanmoins les patients ayant des défauts de perfusion semble présenter un Pronostic plus défavorable (mais seulement n=66/561)

Young LH et al. JAMA **2009**

Effect of Screening for Coronary Artery Disease Using CT Angiography on Mortality and Cardiac Events in High-Risk Patients With Diabetes
The FACTOR-64 Randomized Clinical Trial



2e grande étude porte sur le scanner coronaire

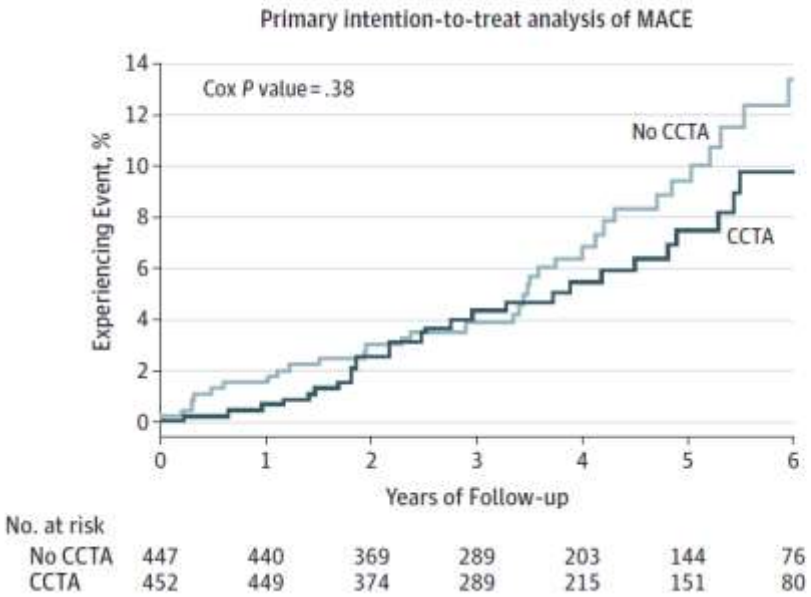
Scanner 64 Barrettes (Toshiba) : coronarographie recommandée

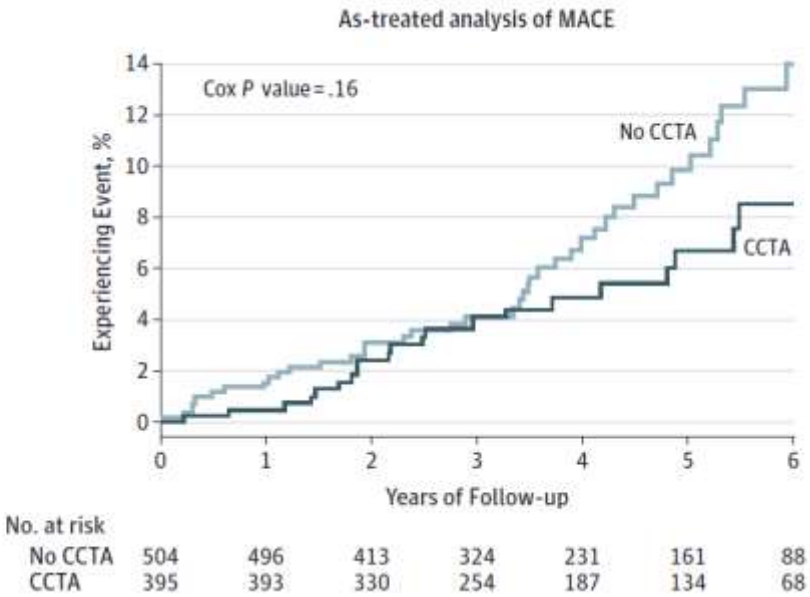
- ou sténose proximale >50%
- si score calcique >100

Joseph B. Muhlestein et al. JAMA **2014**

Effect of Screening for Coronary Artery Disease Using CT Angiography on Mortality and Cardiac Events in High-Risk Patients With Diabetes

The FACTOR-64 Randomized Clinical Trial





Plus d'événements mais pas de différence significative avec une tendance dans le groupe Non dépisté.

Joseph B. Muhlestein et al. JAMA **2014**

Effect of Screening for Coronary Artery Disease Using CT Angiography on Mortality and Cardiac Events in High-Risk Patients With Diabetes
The FACTOR-64 Randomized Clinical Trial

Highest degree of stenosis, No. (%)	
Normal	105 (31.3)
Mild	155 (46.1)
Moderate	40 (11.9)
Severe	36 (10.7)
Highest degree of stenosis in a proximal vessel, No. (%)	
Normal	128 (38.1)
Mild	151 (44.9)
Moderate	36 (10.7)
Severe	21 (6.3)
Vessels with severe proximal disease, No. (%)	
0	315 (93.8)
1	18 (4.6)
2	2 (0.5)
3	1 (0.3)

7% de sténose proximale (>50%), majoritairement mono-tronculaire

Joseph B. Muhlestein et al. JAMA **2014**

Non-invasive screening for coronary artery disease in asymptomatic diabetic patients: a systematic review and meta-analysis of randomised controlled trials

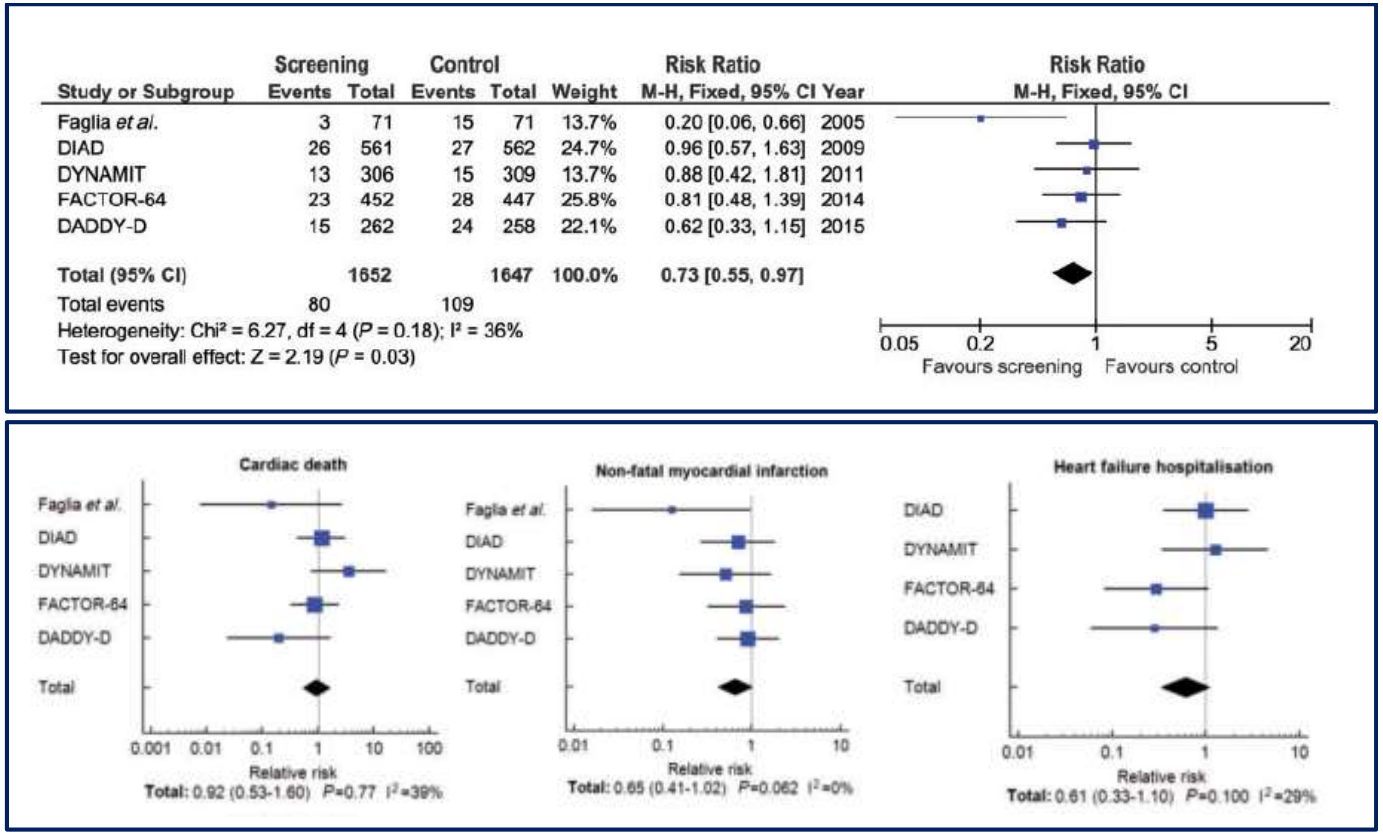
Table 1 Overview of the randomised controlled trials included in the meta-analysis

Study/author	Faglia *et al.*[24]	DIAD[22]	DYNAMIT[35]	FACTOR-64[23]	DADDY-D[36]
Publication year	2005	2009	2011	2014	2015
Patients (*n*)	141 (+1)[a]	1123	615	899	520
Inclusion criteria	• Type 2 DM • 45–76 years old • ≥2 other CVRF	• Type 2 DM • 50–75 years old	• Type 2 DM • 50–75 years old • ≥2 other CVRF	• Type 1 or 2 DM • ♂ ≥50/♀ ≥55, DM for ≥3 years • ♂ ≥40/♀ ≥45, DM for ≥5 years	• Type 2 DM • 50–75 years old • CV risk ≥10% • Sinus rhythm • Able to do EET
Mean age (years)	60.1	60.8	63.9	61.5	61.9
Male gender (%)	55.6	53.5	54.5	52.2	80.0
Screening test	EET and SE	MPI	EET or MPI	CTCA and CACS	EET
Positive screening test	21.1%	5.9% moderate or large defects	21.5% positive or uncertain	11.9% moderate 10.7% severe	7.6%
Treatment strategy	ICA and cardiac follow-up if any test was positive	At the referring physician's discretion	According to the cardiologist's decision	Recommendation based on stenosis severity and CACS	ICA if EET positive
ICA performed after positive test (%)	93.3	15.2	55.9	47.3	85.0
Mean follow-up (years)	4.5	4.8	3.5	4.0	3.6
Annual rate of major CE (%)	1.9	0.6	1.0	0.8	1.4
Main results of screening	Significant ↘ of major and all CE	Non-significant ↘ of major CE	Non-significant ↘ of MI, no effect on combined CE	Non-significant ↘ of combined CE	Non-significant ↘ of major CE, but significant ↘ in >60 years old

Lorsque regarde l'ensemble des études, cette faible prévalence d'événement est caractéristique Des patients asymptomatiques

Olivier F. Clerc et al. Eur Heart J- Cardiov Imaging **2018**

Non-invasive screening for coronary artery disease in asymptomatic diabetic patients: a systematic review and meta-analysis of randomised controlled trials



Cette faible incidence explique que ce n'est qu'en groupant l'ensemble des études
Que l'on retrouve **une différence significatif, principalement sur le risque d'IDM** non fatal
La rentabilité est relativement faible car il faut dépister 50 patients pour éviter un MACE

Olivier F. Clerc et al. Eur Heart J- Cardiov Imaging **2018**

3 Recommandations

ASSISTANCE PUBLIQUE HÔPITAUX DE PARIS

UPEC FACULTÉ DE MÉDECINE

ESC European Society of Cardiology

2023 ESC Guidelines for the management of cardiovascular disease in patients with diabetes

Developed by the task force on the management of cardiovascular disease in patients with diabetes of the European Society of Cardiology (ESC)

- **Non-invasive, routine screening for CAD in asymptomatic patients is not recommended**

Bilan chez tous les diabétiques :

- Créat, bilan lipidique, microalbuminurie, Hbac1%
- ECG

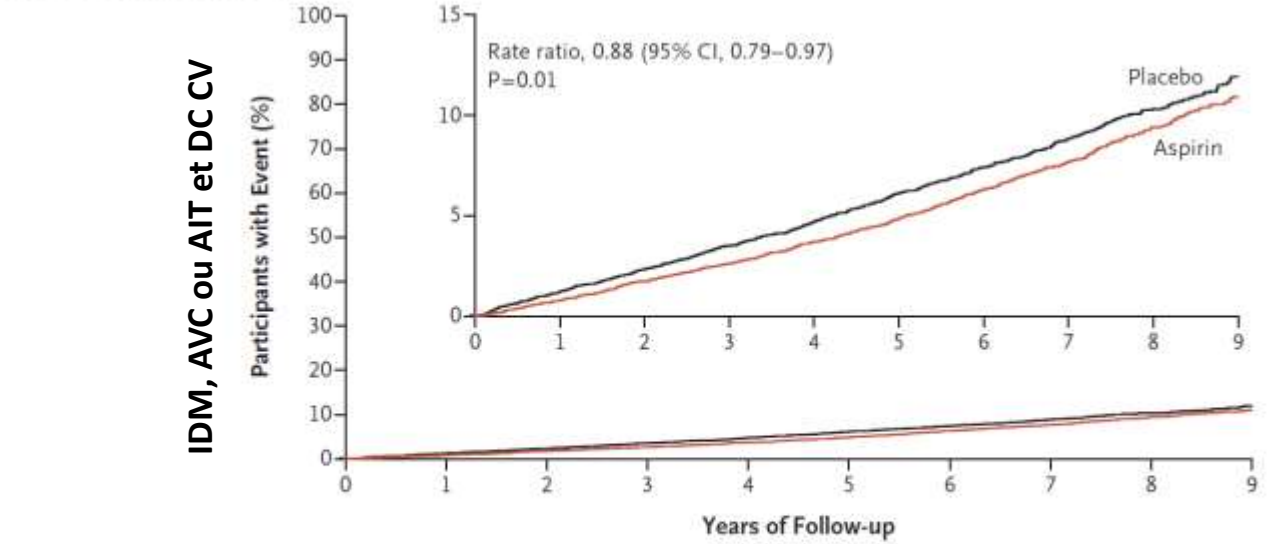
4

Finalement, le patient bénéficie d'un coroscanner qui trouve une sténose de 30% sur l'IVA moyenne. Faut-il mettre sous aspirine?

Effects of Aspirin for Primary Prevention in Persons with Diabetes Mellitus

Characteristic	Aspirin Group (N=7740)	Placebo Group (N=7740)
Age		
Mean — yr	63.2±9.2	63.3±9.2
Vascular risk score — no. (%)¶		
Low	3128 (40.4)	3136 (40.5)
Moderate	3294 (42.6)	3254 (42.0)
High	1318 (17.0)	1350 (17.4)

IDM, AVC ou AIT et DC CV

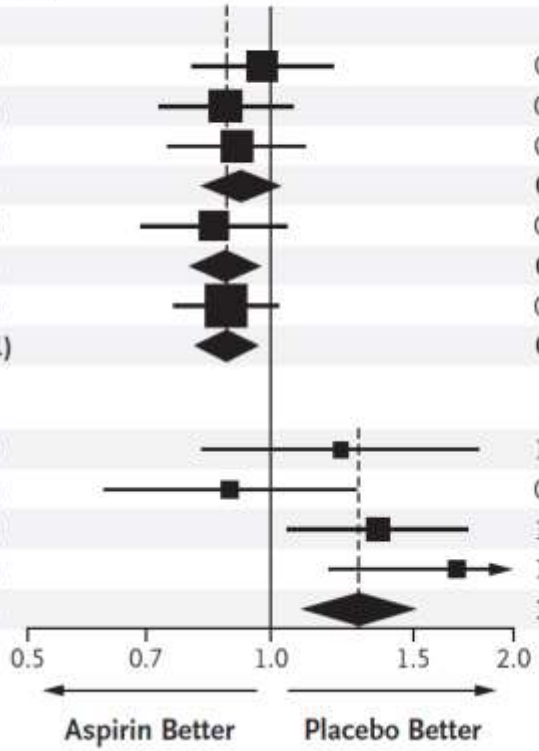


No. at Risk										
Placebo	7740	7618	7486	7342	7188	7001	5771	3890	2200	1430
Aspirin	7740	7655	7536	7404	7252	7096	5825	3966	2222	1428
Cumulative benefit per 1000 participants in aspirin group		4±2	6±2	9±3	10±3	13±4	11±4	12±5	9±6	10±7

ASCEND group, NEJM **2018**

Effects of Aspirin for Primary Prevention in Persons with Diabetes Mellitus

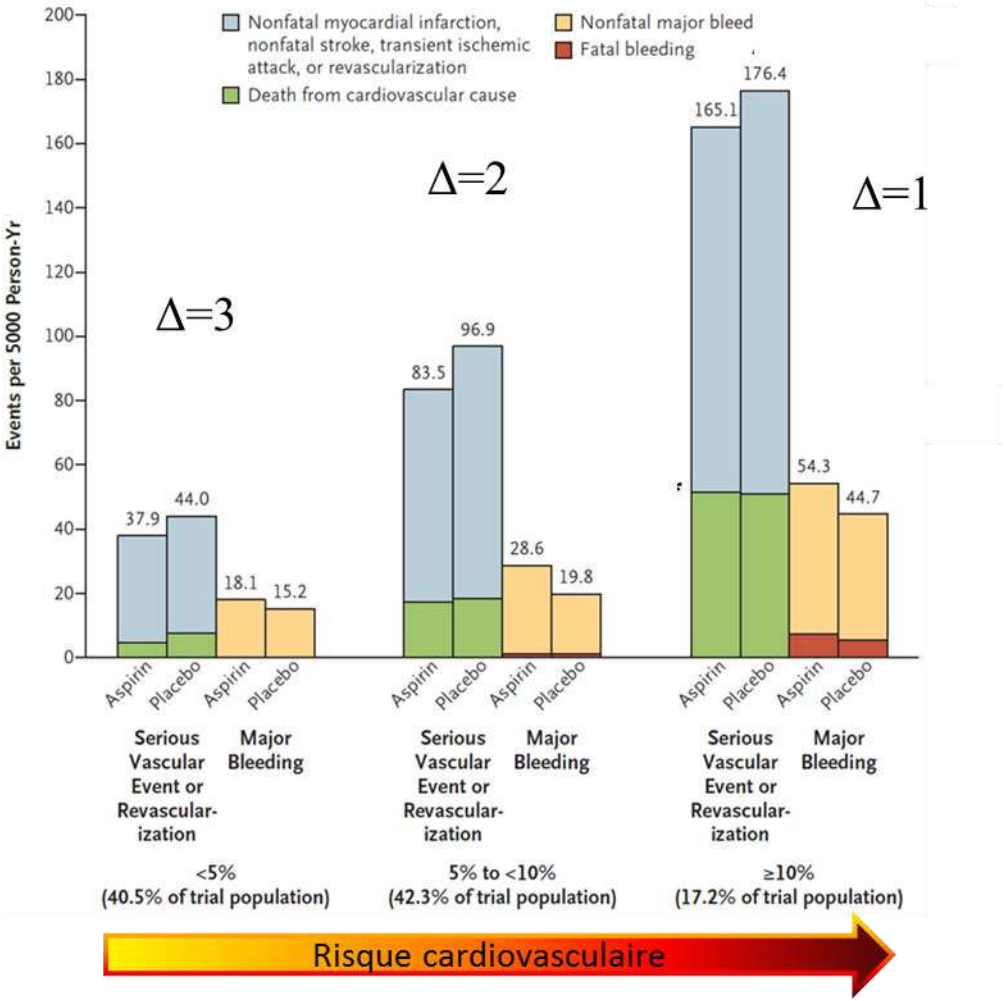
Type of Event	Aspirin (N=7740)	Placebo (N=7740)	Rate Ratio (95% CI)	P Value
	no. of participants with event (%)			
Vascular Outcomes				
Nonfatal myocardial infarction	191 (2.5)	195 (2.5)	0.98 (0.80–1.19)	
Nonfatal presumed ischemic stroke	202 (2.6)	229 (3.0)	0.88 (0.73–1.06)	
Vascular death excluding intracranial hemorrhage	197 (2.5)	217 (2.8)	0.91 (0.75–1.10)	
Any serious vascular event excluding TIA	**542 (7.0)**	**587 (7.6)**	**0.92 (0.82–1.03)**	
TIA	168 (2.2)	197 (2.5)	0.85 (0.69–1.04)	
Any serious vascular event including TIA	**658 (8.5)**	**743 (9.6)**	**0.88 (0.79–0.97)**	**0.01**
Any arterial revascularization	340 (4.4)	384 (5.0)	0.88 (0.76–1.02)	
Any serious vascular event or revascularization	**833 (10.8)**	**936 (12.1)**	**0.88 (0.80–0.97)**	
Major Bleeding				
Intracranial hemorrhage	55 (0.7)	45 (0.6)	1.22 (0.82–1.81)	
Sight-threatening bleeding in eye	57 (0.7)	64 (0.8)	0.89 (0.62–1.27)	
Serious gastrointestinal bleeding	137 (1.8)	101 (1.3)	1.36 (1.05–1.75)	
Other major bleeding	74 (1.0)	43 (0.6)	1.70 (1.18–2.44)	
Any major bleeding	**314 (4.1)**	**245 (3.2)**	**1.29 (1.09–1.52)**	**0.003**



-12% événements CV vs. +29% risque hémorragique

ASCEND group, NEJM **2018**

Effects of Aspirin for Primary Prevention in Persons with Diabetes Mellitus



- ***Nombre évènements évités/5000 patients**

ASCEND group, NEJM **2018**

Aspirine en prévention primaire

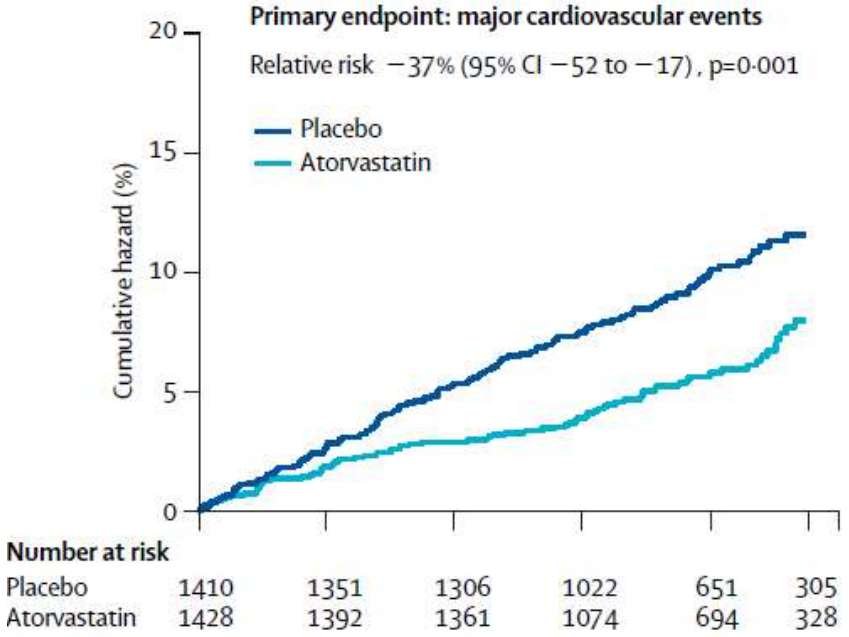
- In summary, in patients with diabetes and no history of symptomatic ASCVD or revascularization, ASA (75–100 mg o.d.) may be considered to prevent the first severe vascular event.
- In patients with diabetes with asymptomatic ASCVD (**including documented CAD confirmed by imaging**) and a higher CV risk, the net benefit of platelet inhibition by ASA may be higher and thus, therapy needs to be individualized.

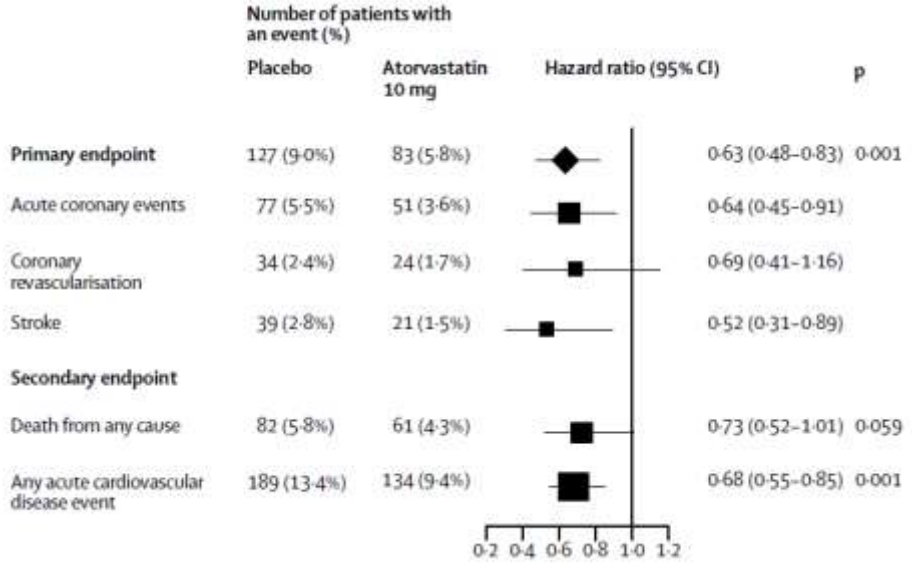
Recommendation	Class[a]	Level[b]
In adults with T2DM without a history of symptomatic ASCVD or revascularization, ASA (75–100 mg o.d.) may be considered to prevent the first severe vascular event, in the absence of clear contraindications.[c,292,293]	IIb	A

5 Faut-il mettre sous statine?

Primary prevention of cardiovascular disease with atorvastatin in type 2 diabetes in the Collaborative Atorvastatin Diabetes Study (CARDS): multicentre randomised placebo-controlled trial

- **Population: Diabétique (n=2838) sans antécédents CV.**
- **Design: Tahor 10 vs. Placébo (LDL moyen=1,2±0,2 g/L)**





Réduction de 37% des MACE (IDM, Angor instable, AVC, ATL, DC CV)

Helen M Colhoun, Lancet 2004

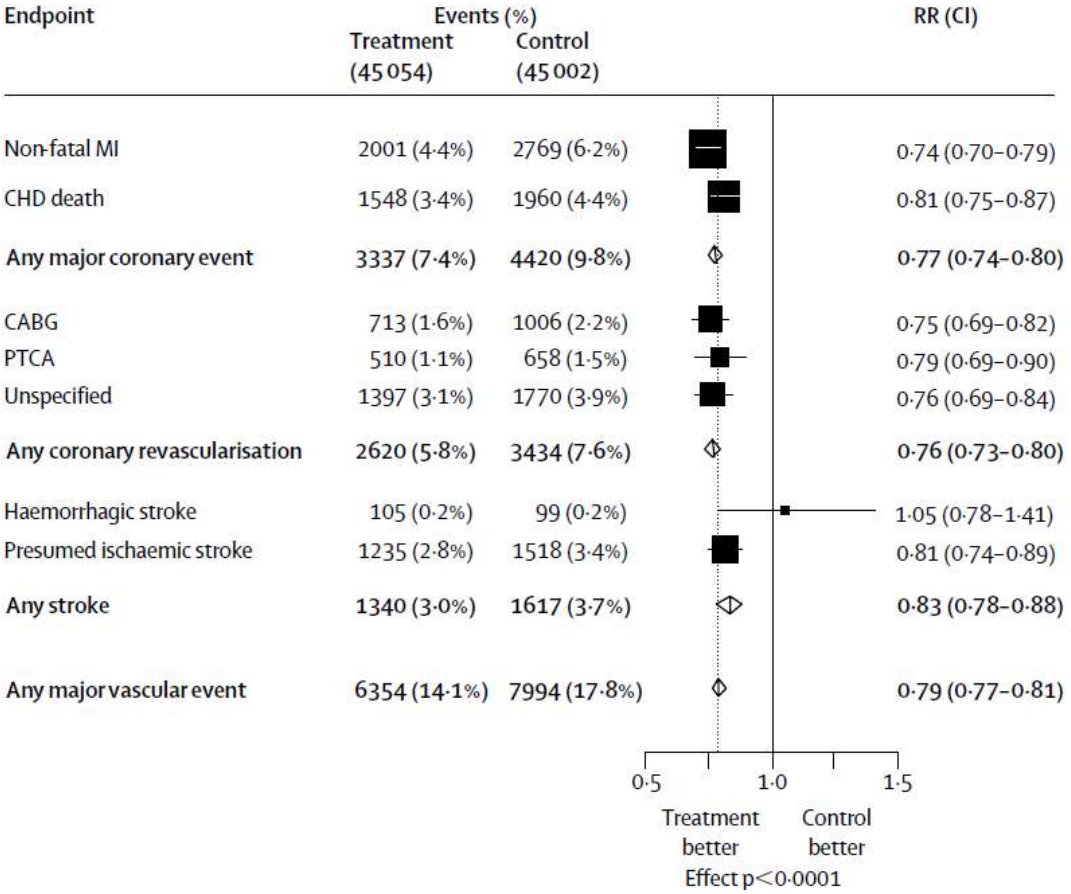
Efficacy and safety of cholesterol-lowering treatment: prospective meta-analysis of data from 90 056 participants in 14 randomised trials of statins

	Dates of recruitment	Year of publication of primary results	Mean duration of follow-up (years)*	Treatment comparison (mg/day)†	Number of patients	Age range (years)	Women (%)	Diabetes (%)	Baseline history of vascular disease (%)			
									MI	Other CHD‡	Other vascular§	None¶
4S	5/1988–8/1989	1994	5·2	S20–40 *vs* placebo	4444	35–70	827 (19%)	202 (5%)	3530 (79%)	914 (21%)	126 (3%)	0
WOSCOPS	2/1989–9/1991	1995	4·8	P40 *vs* placebo	6595	45–64	0	76 (1%)	0	338 (5%)	193 (3%)	6096 (92%)
CARE	12/1989–12/1991	1996	4·8	P40 *vs* placebo	4159	21–75	576 (14%)	586 (14%)	4159 (100%)	0	0	0
Post-CABG	3/1989–8/1991	1997	4·2	L40–80 *vs* L2·5–5	1351	21–74	102 (8%)	116 (9%)	662 (49%)	689 (51%)	37 (3%)	0
AFCAPS/ TexCAPS	5/1990–2/1993	1998	5·3	L20–40 *vs* placebo	6605	45–73 (men) 55–73 (women)	997 (15%)	155 (2%)	0	10 (<1%)	9 (<1%)	6431 (97%)
LIPID	6/1990–12/1992	1998	5·6	P40 *vs* placebo	9014	31–75	1516 (17%)	782 (9%)	5754 (64%)	3248 (36%)	905 (10%)	10 (<1%)
GISSI Prevention	1/1994–5/1996	2000	1·9	P20 *vs* no treatment	4271	19–90	587 (14%)	582 (14%)	4271 (100%)	0	179 (4%)	0
LIPS	4/1996–10/1998	2002	3·1	F80 *vs* placebo	1677	18–80	271 (16%)	202 (12%)	744 (44%)	933 (56%)	142 (8%)	0
HPS	7/1994–5/1997	2002	5·0	S40 *vs* placebo	20 536	40–80	5082 (25%)	5963 (29%)	8510 (41%)	4876 (24%)	8865 (43%)	3161 (15%)
PROSPER	12/1997–5/1999	2002	3·2	P40 *vs* placebo	5804	70–82	3000 (52%)	623 (11%)	776 (13%)	1105 (19%)	1026 (18%)	3254 (56%)
ALLHAT–LLT	3/1994–5/1998	2002	4·8	P40 *vs* usual care	10 355	≥55	5051 (49%)	3638 (35%)	0	1188 (11%)	0	9167 (89%)
ASCOT- LLA	2/1998–5/2000	2003	3·2	A10 *vs* placebo	10 305	40–79	1942 (19%)	2527 (25%)	0	15 (<1%)	1435 (14%)	8860 (86%)
ALERT	6/1996–10/1997	2003	5·1	F40 *vs* placebo	2102	30–75	715 (34%)	396 (19%)	319 (15%)	81 (4%)	241 (11%)	1702 (81%)
CARDS	11/1997–6/2001	2004	3·9	A10 *vs* placebo	2838	40–75	909 (32%)	2838 (100%)	0	9 (<1%)	97 (3%)	2738 (96%)
Total	..	..	4·7	..	90 056	..	21 575 (24%)	18 686 (21%)	28 725 (32%)	13 406 (15%)	13 255 (15%)	41 354 (46%)

META ANALYSE en prévention primaire et secondaire chez le diabétique

Cholesterol Treatment Trialists' (CTT) Collaborators, Lancet 2005

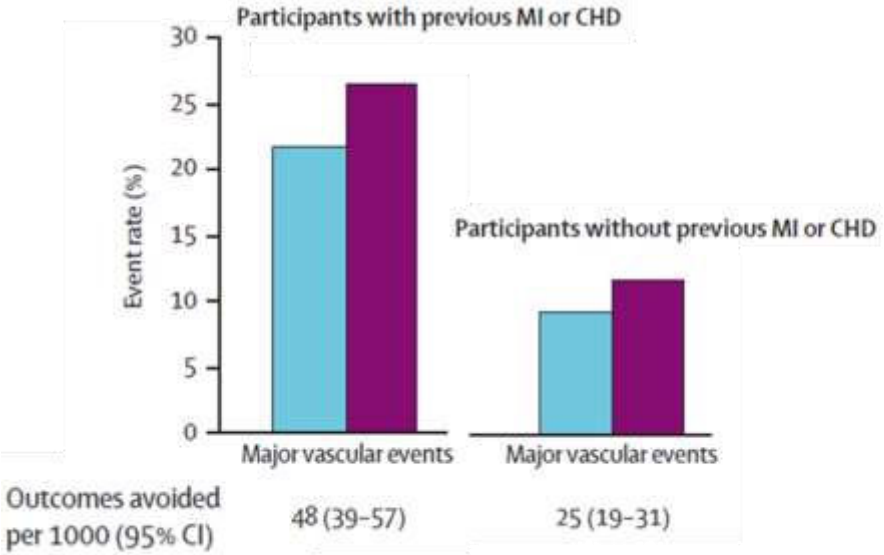
Efficacy and safety of cholesterol-lowering treatment: prospective meta-analysis of data from 90 056 participants in 14 randomised trials of statins

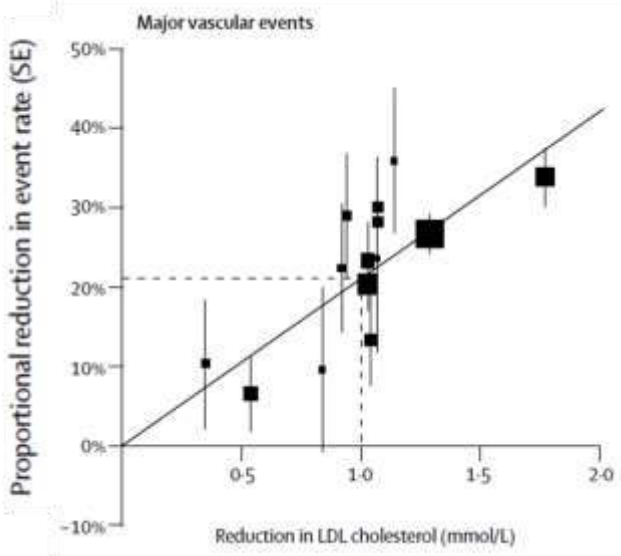


REDUCTION DE 20% DES DECES D'ORIGINE CARDIAQUE+++

Cholesterol Treatment Trialists' (CTT) Collaborators, Lancet 2005

Efficacy and safety of cholesterol-lowering treatment: prospective meta-analysis of data from 90 056 participants in 14 randomised trials of statins





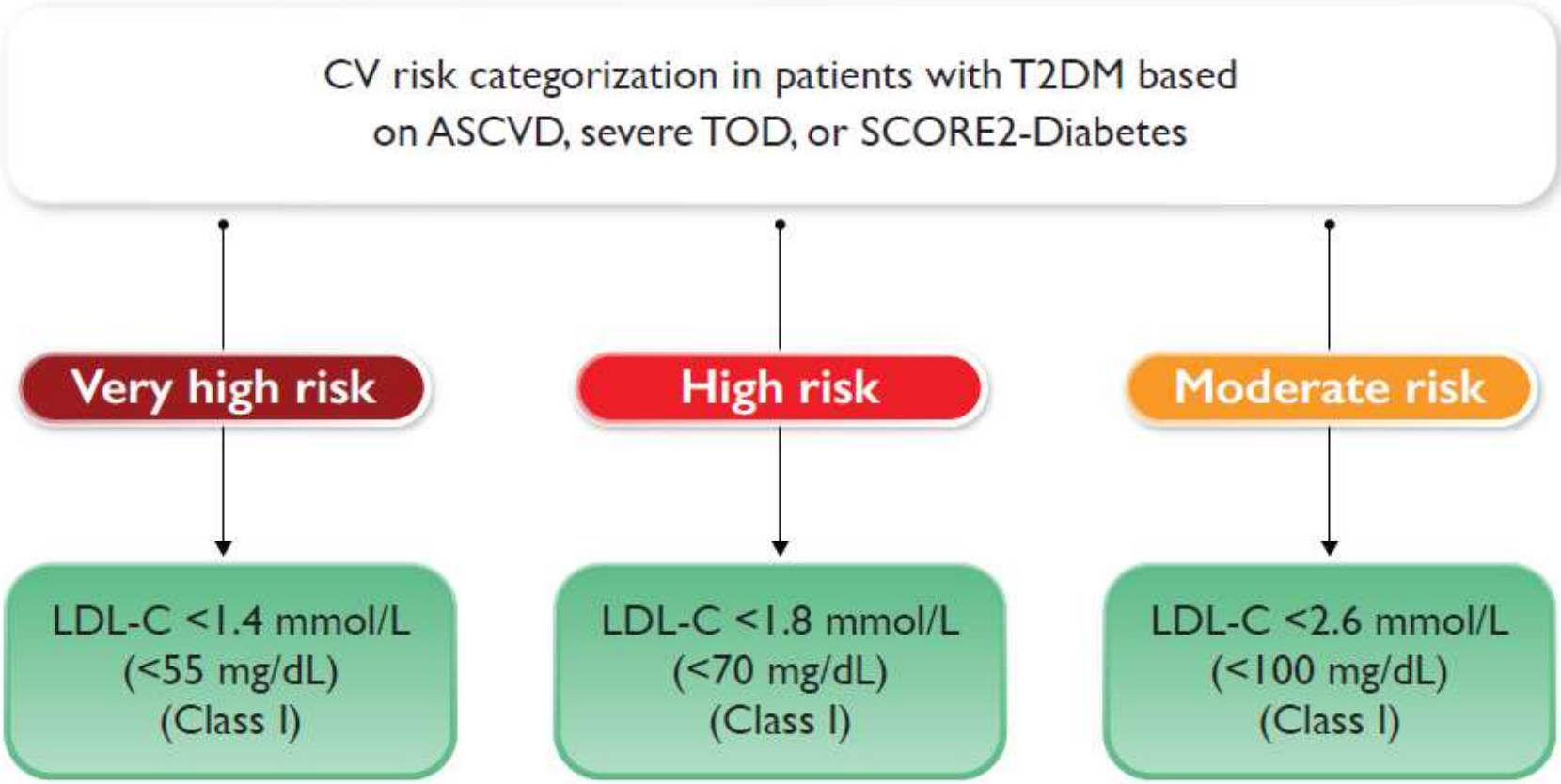
5-year absolute benefits

Groups	Events (%) Treatment (45 002)	Events (%) Control (45 054)	RR (CI)
Previous disease:			
Post-MI	1681 (11·7%)	2207 (15·4%)	0·78 (0·74–0·84)
Other CHD	568 (8·7%)	744 (11·4%)	0·77 (0·68–0·87)
None	1088 (4·5%)	1469 (6·1%)	0·72 (0·66–0·80)

Réduction linéaire / réduction du LDL cholestérol avec un bénéfice en prévention primaire et secondaire

Cholesterol Treatment Trialists' (CTT) Collaborators, Lancet 2005

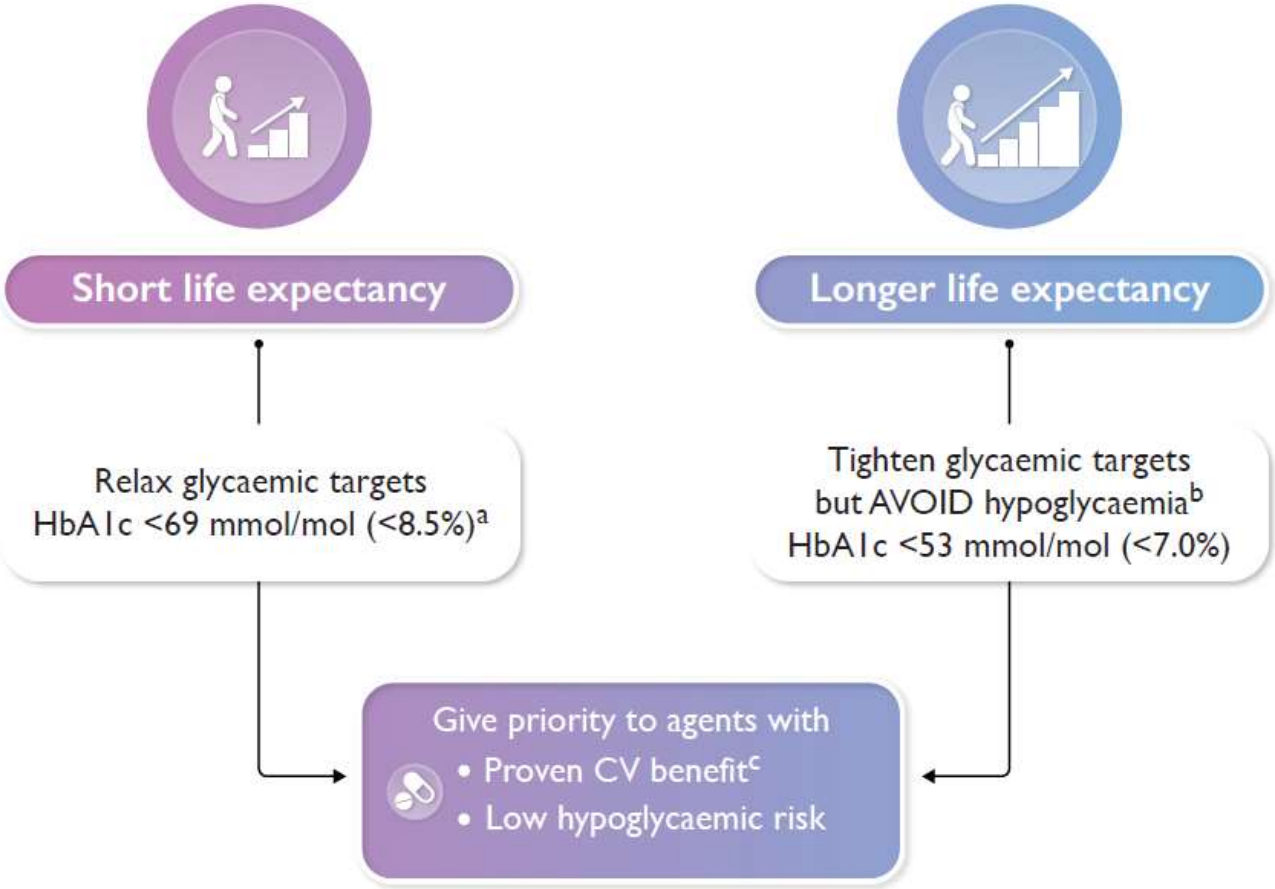
Objectifs des facteurs de risques



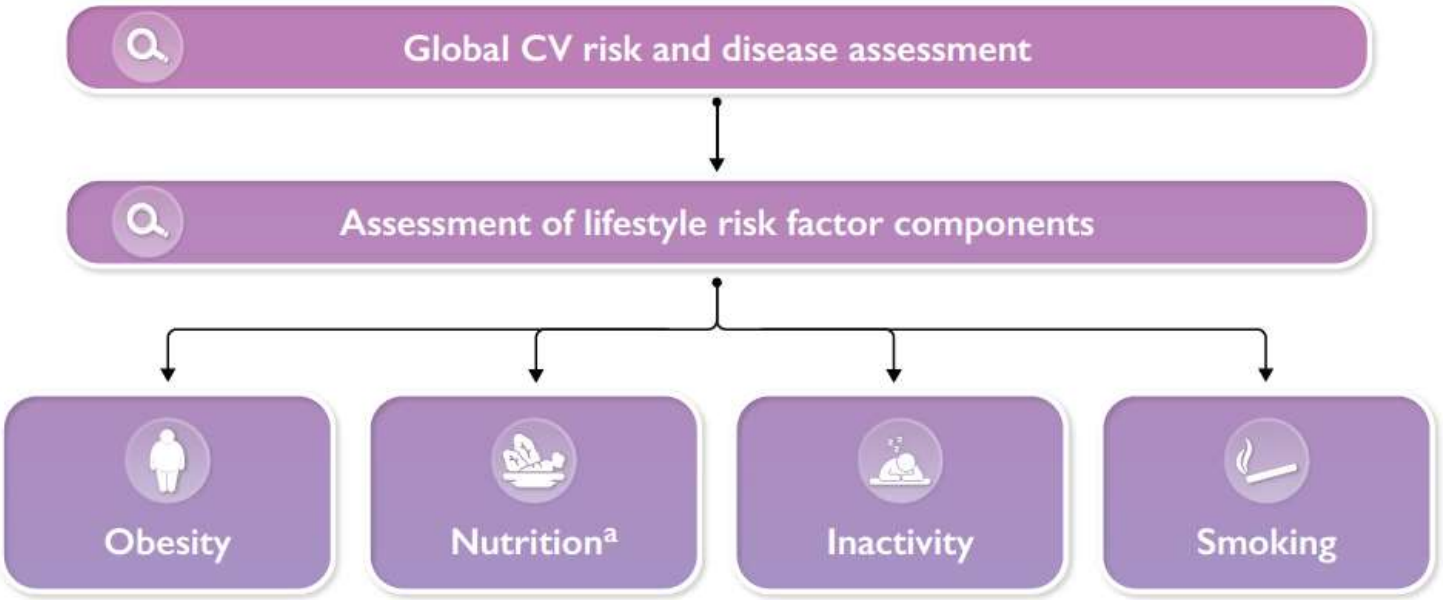
Anti-hypertensive drug treatment is recommended for people with diabetes when office BP is ≥140/ 90 mmHg. Target SBP around 130mmHg.

5 Quel objectif de contrôle du diabète

Objectifs équilibre du diabète



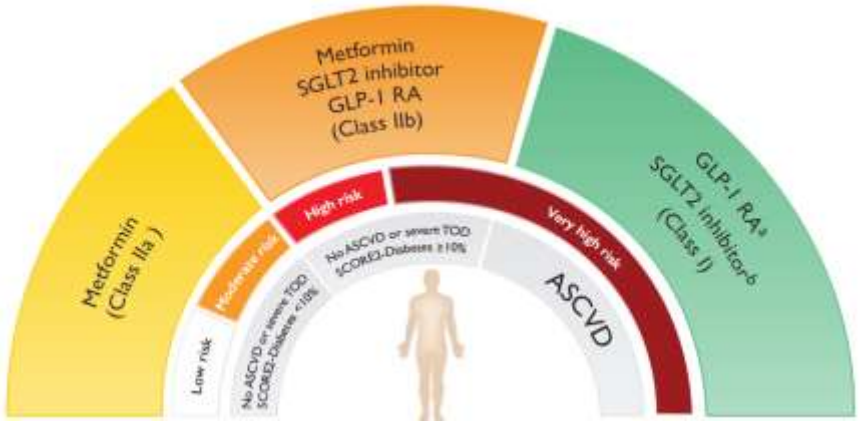
Objectifs des facteurs de risque

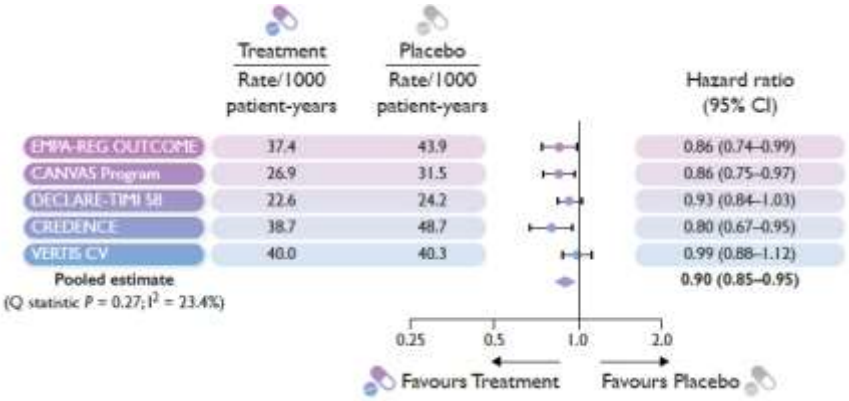


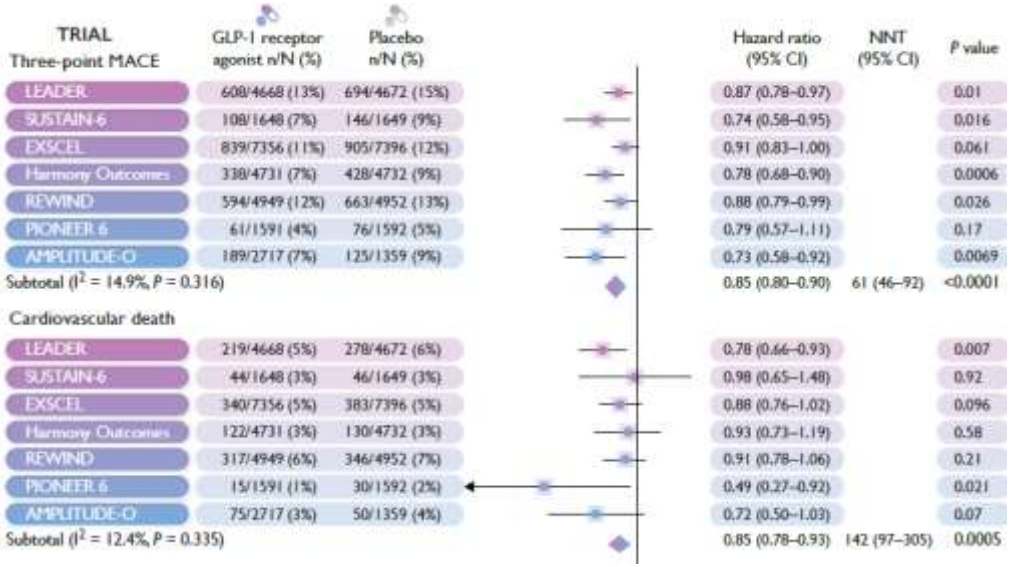
Etude Look AHEAD (n=5145 DNID) montre une reduction de la mortalité (HR 0.79; 95% CI, 0.67–0.94; P = 0.007) chez les patients ayant une perte de poids un an ≥10% un an après le début de l'intervention (encadrement 1/semaine pendant 10 ans)

En pratique:
30min marche par jour (150 min marche par semaine ou 75 min de courses)
Régime méditerranéen – arrêt cigarette

Objectifs équilibre du diabète







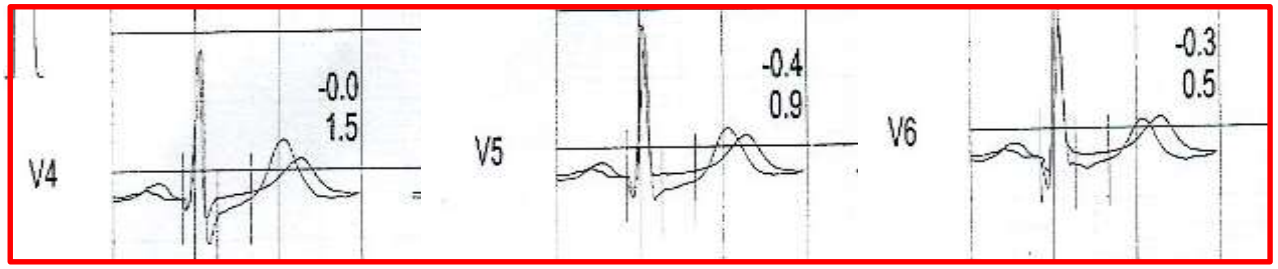
La priorité est donnée aux médicaments permettant de réduire le risque CV +++

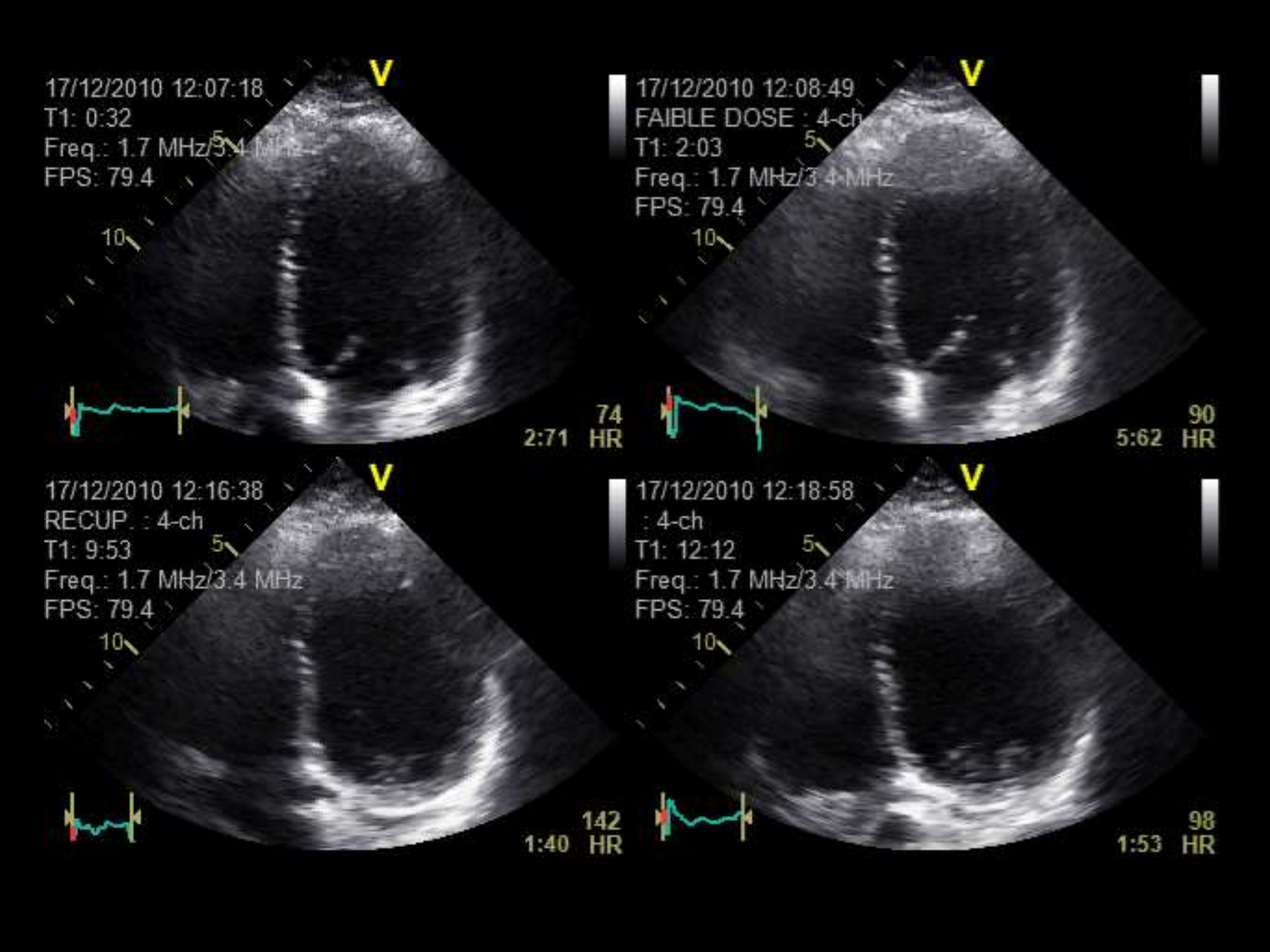
Question

- **Vous revoyez le patient 10 ans plus tard, il vous rapporte une dyspnée à l'effort. La RX de thorax est normale. L'ECG est inchangé et la troponine négative.**

Question

- **Le patient réalise une échographie d'effort qui est menée à 120 watts (88% de la FMT) qui électriquement négative et cliniquement arrêtée pour dyspnée.**

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T1: 0:32
Freq.: 1.7 MHz/3.4 MHz
FPS: 79.4
74
2:71 HR
17/12/2010 12:08:49
FAIBLE DOSE : 4-ch
T1: 2:03
Freq.: 1.7 MHz/3.4 MHz
FPS: 79.4
90
5:62 HR
17/12/2010 12:16:38
RECUP. : 4-ch
T1: 9:53
Freq.: 1.7 MHz/3.4 MHz
FPS: 79.4
142
1:40 HR
17/12/2010 12:18:58
: 4-ch
T1: 12:12
Freq.: 1.7 MHz/3.4 MHz
FPS: 79.4
98
1:53 HR


17/12/2010 12:07:31
T1: 0:45
Freq.: 1.7 MHz/3.4 MHz
FPS: 79.4
69
2:70 HR
17/12/2010 12:09:18
FAIBLE DOSE : 2-ch
T1: 2:32
Freq.: 1.7 MHz/3.4 MHz
FPS: 79.4
89
4:59 HR
17/12/2010 12:16:50
RECUP. : 2-ch
T1: 10:05
Freq.: 1.7 MHz/3.4 MHz
FPS: 79.4
118
1:44 HR
17/12/2010 12:19:05
: 2-ch
T1: 12:19
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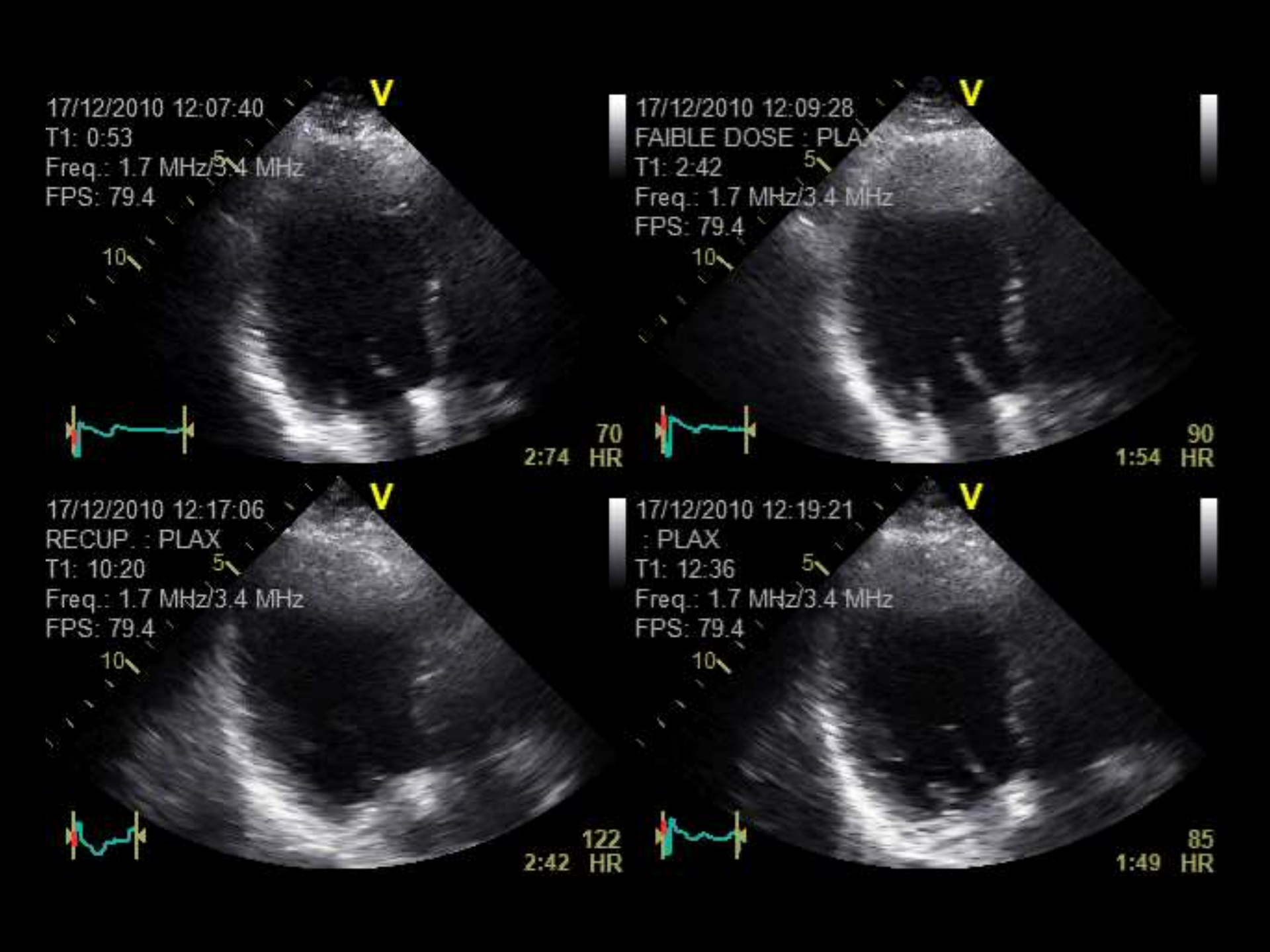
FPS: 79.4
94
1:56 HR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Freq.: 1.7 MHz/3.4 MHz
FPS: 79.4
70
2:74 HR
17/12/2010 12:09:28
FAIBLE DOSE : PLAX
T1: 2:42
Freq.: 1.7 MHz/3.4 MHz
FPS: 79.4
90
1:54 HR
17/12/2010 12:17:06
RECUP. : PLAX
T1: 10:20
Freq.: 1.7 MHz/3.4 MHz
FPS: 79.4
122
2:42 HR
17/12/2010 12:19:21
: PLAX
T1: 12:36
Freq.: 1.7 MHz/3.4 MHz
FPS: 79.4
85
1:49 HR