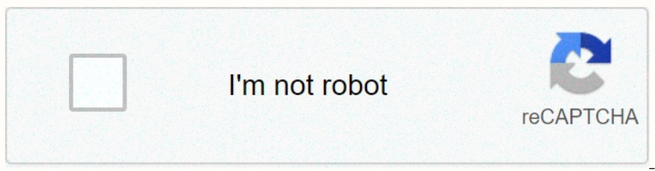

Continue

Aha lipid guidelines 2018 pdf

November 10th, 2018 | Melvyn Rubenfire, MD, FACC Authors: Grundy SM, Stone NJ, Bailey AL, et al. Quote: 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/ APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Practice Guidelines. J Am Coll Cardiol 2018; November 10:[Epub before press]. Below are the key views of the 2018 Multisociety Guidelines on Blood Cholesterol Management, based on the top ten take home messages selected by the writing committee. The 2018 guideline emphasizes reducing the risk of atherosclerotic cardiovascular disease (ASCVD) through lipid management. It updates the 2013 guidelines and highlights a more intensive approach based on recent controlled studies and expert consensus. An accompanying review of risk assessment tools to guide decision-making for ascvd prevention is very useful (see Lloyd-Jones DM, et al., Special Report on the use of risk assessment tools to guide decision-making in the primary prevention of ASCVD. J Am Coll Cardiol 2018; November 10:[Epub before printing]). I took the liberty of using the 10 important points selected by the Writing Committee and making comments (in italics) based on other content and my clinical practice and experience. In all individuals, emphasize a lifestyle healthy for the heart during the course of life. A healthy lifestyle reduces ASCVD risk at all ages. In younger individuals, a healthy lifestyle can reduce the development of risk factors and is the basis of ASCVD risk reduction. In young adults aged 20 to 39, a t-life risk assessment facilitates discussion about doctor-patient risk and emphasizes intensive lifestyle efforts. In all age groups, lifestyle therapy is the primary intervention for metabolic syndrome. Expert Perspective: As with generalized obesity, lifestyle changes to eliminate one or more components of metabolic syndrome often need a multidisciplinary effort for long periods of time to prevent recurrence. In patients with clinical ASCVD, reduce low-density lipoprotein cholesterol (LDL-C) with high-intensity statins or maximum tolerated statins to reduce the risk of ASCVD. Higher LDL-C reductions on static therapy, leading to lower LDL-C levels, lower significant risk. Use a maximum tolerated statin to reduce LDL-C levels by ≥50%. Expert Perspective: The guiding definition of clinical ASCVD includes stroke, transient ischemic attack (TIA), documented coronary artery disease (CAD) with stable angina, acute coronary syndromes (ACS), coronary revascularization or other peripheral vascular disease with or without claudication and aortic aneurysm. While risk estimates for deciding preventive therapies should not include stress tests or cardiac ultrasound, in men and women with a risk of ≥5% 10 years for CV events, I would include ASCVD in asymptomatic CAD with ischemia defined by stress electrocardiography (ECG) or stress stress In those who are at low risk with evidence of ischemia, adding a coronary calcium score (CAC) would help clarify the risk. In high-risk ASCVD, use an LDL-C threshold of 70 mg/dl (1.8 mmol/L) to consider adding nonstatins to statins. In patients with very high-risk ASCVD, it is reasonable to add ezetimibe to maximum static therapy when the LDL-C level remains ≥70 mg/dl (≥1.8 mmol/L). In patients at very high risk whose LDL-C level remains ≥70 mg/dl on maximum tolerated statin and ezetimibe therapy, the addition of a PCSK9 inhibitor is reasonable, even if long-term safety (>3 years) is uncertain and the cost-effectiveness ratio is low at mid-2018 prices. Expert Perspective: The very high risk for future ASCVD events includes a history of multiple major ASCVD events (ACS within 12 months, myocardial infarction, ischemic stroke, peripheral arterial disease defined as claudication with ankle-brachial index [ABI] 2, current smoker and LDL-C ≥100 mg / dl despite the maximum tolerated static therapy and ezetimibe. These recommendations extend the use of PCSK9 inhibitors to patients included in outcome studies that have shown that LDL-C is better and safer at very low levels. In patients with severe primary hypercholesterolemia (LDL-C level ≥190 mg/dl [≥4.9 mmol/L]) without calculating the ASCVD risk at 10 years, start static high-intensity therapy. If the LDL-C level remains ≥100 mg/dl, the addition of ezetimibe is reasonable. If the LDL-C level on more ezetimibe statins remains ≥100 mg/dl and the patient has multiple factors that increase the subsequent risk of ASCVD events, a PCSK9 inhibitor may be considered, even if the long-term safety (>3 years) is uncertain and the economic value is uncertain at mid-2018 prices. Expert Perspective: Patients with HeFH are approved by the Food and Drug Administration (FDA) and most PCSK9 inhibitor therapy insurance carriers regardless of the presence of ASCVD due to a very high risk. Those with HeFH and an LDL-C of 190 mg/dl have a 3-4 times higher risk of CV events than others at the same LDL-C level and a 20 times higher risk than those with an LDL-C of 130 mg/dl. HeFH is more common than previously thought and should be considered in all people with early coronary heart disease and those with elevated LDL-C and family members with premature CAD or high LDL-C. In patients aged 40 to 75 with diabetes mellitus and an LDL-C level of ≥70 mg/dl, start moderate intensity statins without calculating ascvd risk at 10 years. In patients with higher-risk diabetes mellitus, especially those with multiple risk factors or those aged 50 to 75, it is reasonable to use a high-intensity statin reduce the LDL-C level by ≥50%. In adults aged 40 to 75 evaluated for primary ASCVD prevention, have a discussion about doctor-patient risk before starting static therapy. The risk discussion should include a review of the main risk factors (e.g. cigarette smoking, high blood pressure, LDL-C, hemoglobin A1c [if indicated], indicated], calculated 10-year risk of ASCVD); the presence of risk-enhancing factors (see #8); the potential benefits of lifestyle and statin therapies; the potential for adverse effects and drug-drug interactions; consideration of the costs of statin therapy; preferences and values of patients in shared decision-making. Expert Perspective: Primary care physician time constraints often require the use of non-physical providers trained for risk assessment and discussion and referral to lipid or other prevention specialists, particularly for patients with a family history of early coronary heart disease and major risk factors. In adults aged 40 to 75 without diabetes mellitus and with LDL-C levels ≥70 mg/dl (≥1.8 mmol/L), with a 10-year ASCVD risk of ≥7.5%, initiate a statin of moderate intensity if a discussion of treatment options favors static therapy. Risk-enhancing factors favor static therapy (see #8). If the risk status is uncertain, consider using call admission control to improve specificity (#9). If statins are indicated, reduce LDL-C levels by ≥30% and if the 10-year risk is ≥20%, reduce LDL-C levels by ≥50%. Expert perspective: If the patient is considered an intermediate risk but there are risk improvement factors ≥1 or a high CAC score as in #8 and #9, you can discuss the higher intensity statin as an option. In adults aged 40 to 75 without diabetes mellitus and a 10-year risk of 5%-19.9%, risk-enhancing factors favor the onset of static therapy. Risk-enhancing factors include the family history of premature ASCVD; consistently high LDL-C levels ≥160 mg/dl (≥4.1 mmol/L); metabolic syndrome; chronic kidney disease; History of preeclampsia or premature menopause (age Expert Perspective: Other risk-enhancing factors include systemic lupus and radiotherapy for left breast cancer and other radiation therapies in which the main left, left anterior descent, and next-hand coronary artery are in the field. In adults aged 40 to 75 without diabetes mellitus and with LDL-C levels ≥70 mg/dl-89 mg/dl (≥1.8-4.9 mmol/L), with a 10-year ASCVD risk of ≥7.5%-19.9%, if a decision on statin therapy is uncertain, take into account the measurement of the CAC. If the CAC score is zero, treatment with static therapy may be retained or delayed, except in cigarette smokers, those with diabetes mellitus, and those with a strong family history of premature ASCVD. A CAC score of 1-99 favors static therapy, especially in >55 years. For any patient, if the CAC score is ≥100 Agatston units or ≥75th percentile, statin therapy is indicated if not otherwise the outcome of the discussion on medical-patient risk. Expert perspective: Unfortunately, screening using CAC is patient payment at a cost of $75-$350. Considering that it can run at a cost less than the cost of an ECG and that the results are of great impact, it makes no sense that it is not paid for by third parties. CAC has replaced expensive old-fashioned tests for ischemia. High CAC scores have been shown to improve compliance lifestyle behavior and help patients decide on a long-term treatment strategy in the absence of symptoms. Evaluate adherence and percentage response to drugs that lower LDL-C and lifestyle changes with repeated measurement of lipids from 4 to 12 weeks after the onset of statin or dose regulation, repeated every 3-12 months as needed. Define lifestyle and static therapy responses based on percentage reductions in LDL-C levels versus baseline. In very high-risk ASCVD patients, the triggers for the addition of non-statistical drugs are defined by the LDL-C threshold levels ≥70 mg/dl (≥1.8 mmol/L) on maximum statin therapy (see #3). Clinical topics: diabetes and cardiometabolic diseases, Dyslipidemia, angiography and invasive cardiovascular intervention, non-invasive imaging, prevention, lipid metabolism, nonstatins, new agents, statins, interventions and imaging, computer tomography, nuclear imaging, diet, exercise keywords: atherosclerosis, body weight changes, cardiac imaging techniques, cholesterol, cost-benefit analysis, costs and cost analysis, decision making, diabetes mellitus, diet, dyslipidmias, exercise, HIV infections, Hydroxythylglutaril-CoA reductase inhibitors, inflammation, multidetector computer tomography, lifestyle, lipids, lipoproteins, mass screening, metabolic syndrome X, motor activity, patient compliance, plaque pediatrics, atherosclerotics, primary prevention, kidney failure, chronic, risk assessment, risk factors, risk reduction behavior, safety, secondary prevention, life value, vascular diseases, women < back to listing