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Clinical Practice Guidelines for Hyperlipidemia: What Are the Recommendations?

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Maron:
This is CME on ReachMD, and I'm Dr. David Maron. Today, my topic is primary prevention of atherosclerotic cardiovascular disease, or ASCVD. The most important way to prevent ASCVD is to promote a healthy lifestyle throughout life.

A diet emphasizing vegetables, fruits, legumes, nuts, whole grains, and fish is recommended by primary prevention guidelines to decrease ASCVD risk. Replacement of saturated fat with dietary monounsaturated fat and polyunsaturated fat is beneficial. And a diet reducing the amount of cholesterol and sodium is also a benefit. As part of a healthy diet, it's reasonable to minimize the intake of processed meats, refined carbohydrates, and sweetened beverages and to eliminate trans fats completely from the diet.

Exercise of moderate intensity is recommended for at least 150 minutes per week for all adults and/or 75 minutes per week of vigorous intensity physical activity.

Now all adults should undergo risk assessment and those 40 to 75 years of age should have a 10-year risk of ASCVD calculated by using the pooled cohort equations. Risk assessment for primary prevention is geared primarily to guide the decision about whether or not to start statin therapy because LDL cholesterol is such an important risk factor in the initiation and progression of atherosclerotic plaque. A general principle is that the intensity of therapy should be proportional to the level of risk.

In adults at intermediate risk, which is defined as 7.5% to less than 20% 10-year ASCVD risk, or some individuals at borderline risk, meaning 5% to less than 7.5%, patients and clinicians should have a risk-based discussion about whether or not to start a statin. And if the decision is made to start a statin, the guidelines recommend moderate-intensity statin therapy to achieve a 30% reduction in LDL or more.

If risk-based discussions for preventive interventions remain uncertain, then the guidelines say it's reasonable to measure a coronary artery calcium [CAC] score to guide the clinician-patient risk discussion.

With anatomic information about atherosclerosis in asymptomatic people, the distinction between primary and secondary prevention becomes blurred, and care can be more personalized with the anatomic information. For example, someone with a CAC score of 300 or greater has the same risk as somebody with a history of MI [myocardial infarction], stroke, or peripheral artery disease. Coronary CT [computed tomography] angiography provides even more information about the total atherosclerotic burden and plaque composition. So how should anatomic information affect LDL goal-directed therapy?

Well, LDL goals went out of fashion years ago, but they're making a comeback. For primary prevention, a minimum LDL goal of less than 100 is generally recommended. For secondary prevention, an LDL goal less than 70, and for people with ASCVD at very high risk, an LDL goal of less than 55 is recommended.

Despite these guidelines for primary prevention, only 35% of adults who are eligible to take statins actually take them. Statins have developed a stigma, mostly for the wrong reasons. Some patients have true statin intolerance. Others have heard a lot of rumors about why statins are bad for you, and there's a lot of misinformation and disinformation out there. But fortunately, there are several nonstatin drugs now available to help patients achieve their LDL goals.

In summary, a healthy lifestyle is recommended throughout the lifespan. Risk assessment is recommended for all adults. A general principle is that the intensity of therapy should be proportional to the level of risk. Patients at intermediate risk should have a risk-based discussion with their clinician about starting a statin. Anatomic testing helps refine risk assessment, but it blurs the line between primary and secondary prevention. Adherence to guidelines when it comes to statin therapy is poor. New nonstatin therapies to lower LDL cholesterol are available to help patients with statin intolerance reach their LDL goals.

Thanks for your attention.

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