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Why It's Time to Reassess LDL-C Goals in Your Patients with Recent MI

Announcer:
You're listening to ReachMD. This medical industry feature, titled "Why It's Time to Reassess LDL-C Goals in Your Patients with Recent MI" is sponsored by Amgen. This program is intended for physicians.

Here's your host, Dr. Pam Taub.

Dr. Taub:
For patients who have recently experienced a myocardial infarction, cholesterol management is critical to help reduce the risk of recurrent cardiovascular events, such as MI or stroke. However, it may not always rise to the highest priority during hospital discharge and subsequent follow-up. In this episode we will explore why patients with a recent myocardial infarction occurring within the previous 12 months are among the highest risk patients for recurrent cardiovascular events and what can be done to better manage that risk. At a time of the COVID-19 pandemic when patient behavior and clinical practice methods are impacted, what can we do to better help protect patients? And how can we continue to improve the way we manage cholesterol levels in this high-risk population and help reduce the risk of subsequent cardiovascular events?

This is ReachMD, and I'm Dr. Pam Taub, a cardiologist and Associate Professor of Medicine and Director of the Step Family Foundation Cardiovascular Rehabilitation and Wellness Center at UC San Diego Health in California. Here with me today is my colleague, Dr. Sripal Bangalore, who is an interventional cardiologist, Professor of Medicine and Director of the Cardiac Catheterization Laboratory at the Bellevue Hospital at NYU Langone Health in New York.

Dr. Bangalore, welcome to the program.

Dr. Bangalore:
Thank you. It's great to be on, especially discussing this very important topic.

Dr. Taub:
I want to start our discussion today with a patient I recently saw. He's a 56-year-old male with type 2 diabetes, peripheral arterial disease, who was recently admitted for acute coronary syndrome and had a stent placed to the mid LAD. He's seen in clinic after discharge and has an LDL cholesterol of 85 with a regimen that consists of a high-intensity statin and ezetimibe.

So, Dr. Bangalore, for a high-risk patient like this, can you give us a better sense of why this focus on cholesterol management in patients with recent MI is so important, particularly from the perspective of an interventional cardiologist?

Dr. Bangalore:
Absolutely. I think the case you described, unfortunately we're seeing it more and more often these days, patients with multiple risk factors, multiple atherothrombotic events coming in with ACS. And I think the key thing to emphasize for such patients is many times in the cath lab we do show them the films, and we show them where their blockages are, so it's an opportunity for patient education, but what we know from data is that the risk of cardiovascular events following an MI is high, especially during the first year, and we know from a number of registries. For example, the REACH registry shows that approximately 30% of patients will have a recurrent event over 4 years and that cardiovascular event rates are highest in patients with prior event occurring within 1 year, so the perfect example is the patient you just described. As you know, LDL cholesterol is one of the most modifiable risk factors independently associated with atherosclerosis and which has a significant impact on the risk of future cardiovascular events, and I think this is a great case example.

For a patient like this in the cath lab, we do some patient education, etc., and then they are left to their treating cardiologists who go ahead and manage their subsequent care. For a patient like this, there are a number of guidelines. What do current guidelines recommend? How should we be managing their lipid levels?

Dr. Taub:
The 2018 ACC/AHA cholesterol guidelines define very high-risk patients as those with multiple major atherosclerotic cardiovascular events, including recent acute coronary syndrome, history of myocardial infarction, or 1 major ASCVD event—and multiple high-risk conditions, such as diabetes, hypertension, age greater than 65, smoking, heterozygous familial hypercholesterolemia and congestive heart failure. For these patients the guidelines define an LDL-C threshold of 70 for intensifying lipid-lowering therapy by adding nonstatin medications on top of maximally tolerated high-intensity statins. The ESC, or the European 2019 cholesterol guidelines, define goals for very high-risk patients at less than 55, and they recommend a greater than 50% reduction from baseline. For patients with multiple vascular events within 2 years, a lower LDL-C goal of less than 40 may be considered. Both guidelines recommend lower is better.

For instance, with our patient who has an LDL of 85, we haven't met either of the guidelines, and we need to be aiming for a lower target LDL.

In my practice I follow the ESC guidelines. What do you follow, Dr. Bangalore?

Dr. Bangalore:
Yeah, so those are great points. I completely agree. Lower seems to be better, and that is exactly what I believe in, but we also know, unfortunately—this is data from multiple observational studies—that only 40–50% of patients with a recent MI or ACS achieve even the recommended goal of less than 70 mg/dL. I do agree that there are huge opportunities to further improve care of these very high-risk patient subgroups.

Dr. Taub:
On the subject of risk stratification, Dr. Bangalore, how many ASCVD patients do you think meet the definition of very high risk? And how does their risk compare to other groups?

Dr. Bangalore:
Yeah, great point. I must say, just stepping back as an interventional cardiologist—and also this is true for many of the clinical cardiologists—that we tend to lump patients with, for example, a recent MI into 1 bucket. We know that they are high risk. And you nicely pointed out that we can carve out a very high-risk subgroup as patients with multiple atherosclerotic cardiovascular events, 1 major event and risk factors, so I think that categorization is critically important. And I think, based on recent data, approximately, I would say, 50% of patients with a history of atherosclerotic cardiovascular disease met the definition of very high risk. And most had major atherosclerotic cardiovascular events and multiple high-risk condition. In fact, 1 in 4 patients had multiple major atherosclerotic cardiovascular events, so it is fairly common.

And to your second point, in terms of the risk, in the same study there was about a 3-fold higher rate of recurrent cardiovascular events, like myocardial infarction and stroke, in patients meeting the definition of very high risk with the highest rates, as you may expect, in patients with multiple major atherosclerotic events. And I think this is the critically important piece of data to suggest that just classifying all MIs as high-risk may not be helpful. There is a higher-risk subset within that high-risk category, but again, I want to point out that less than 40% of patients who met the 2018 AHA/ACC guideline definition of very high risk were, in fact, taking a high-intensity statin. There are a lot more things that we could do in kind of optimizing patient care.

So, for those just tuning in, you're listening to ReachMD. I'm Dr. Sripal Bangalore, and today I'm speaking with Dr. Pam Taub about some key considerations for improving cholesterol management in patients who have recently experienced a myocardial infarction.

So, Dr. Taub, once a patient has an MI, what strategies do you prioritize to help prevent future cardiovascular events?

Dr. Taub:
Great question. There are multiple opportunities across the continuum of care of post myocardial infarction patients to optimize LDL cholesterol and to help reduce the risk of future cardiovascular events. These involve coordination between interventional cardiologists and the general cardiologist as well as the advanced care practitioners who are an integral part of our team, and working together we can all make an impact on how these patients are managed after they have had a myocardial infarction. Some of these strategies include obtaining lipids; including lipid-lowering treatment at the time of hospital discharge. As you pointed out earlier, educating patients at the time of the event is important. I like how you show the patients their angiograms because it's really important for patients to visualize their disease. I also passionately believe in cardiac rehabilitation. And you may want to consider a lipid clinic referral at discharge if that's available and then obtaining a lipid panel 1–3 months after discharge to continue evaluating therapy. We need to

remember that LDL is not a static number. It's a dynamic number that needs to be continuously evaluated. And then we want to think about intensifying therapy when LDL-C is above threshold to achieve the LDL-C goal as appropriate. We need to remember that per the AHA/ACC guidelines that 70 is not a target; it's a threshold.

Now, let's consider how the care of these patients needs to change and adapt with what's going on currently with the COVID-19 pandemic that we're facing. What are some factors we need to keep in mind?

Dr. Bangalore:
Yeah, so great question. I think New York being the epicenter, at least a few months ago, for this COVID-19 pandemic, and I think it kind of reinforced some of the prior practices or at least some of the things that we were emphasizing. For example, if a patient is admitted to the hospital with an MI, this is an opportunity to maximize their medical care. In other words, gone are the times when we used to say let's start 1 agent at a time, follow them up for 4–6 weeks, etc., and escalate therapy. And we know from data from a number of studies in the past that maximizing at the time of discharge would mean that the patients are more likely to be on these medications.

So I can tell you that during this COVID-19 pandemic,—it made us feel that absolutely we need to do this because there is decrease in patient visits for follow-up, many times we're doing tele-visits, and so maximizing at the time of discharge is critically important. There is also need for continued and more proactive follow-up, monitoring of lipid panel, ensuring that appropriate intensification of lipid-lowering therapy does occur, so we have to make sure that therapeutic inertia does not set in. And I think one thing that COVID-19 is bringing to the forefront is the use of telemedicine, and I think this new reality will likely define medicine going forward. I think this is critically important as we care for these patients.

So my take-home from what we've seen with COVID pandemic is try to maximize at the time of discharge, have very close follow-up on these patients. You're likely going to have tele-visits, so you just have to figure out ways to say, "Okay, I'm going to check their lipid panel again, follow-up," and, "How can I get it done if the patients are reluctant to come into the hospital?"

Dr. Taub, what have you seen in terms of COVID-19 patients in your own experience with this?

Dr. Taub:
Great points that you've made about the impact of COVID on our patients with cardiovascular disease. COVID really has impacted our patients who have underlying cardiometabolic disease, so we need to focus on the treatment of these underlying risk factors, such as their hypertension, their type 2 diabetes, and really improve the resilience of our patients.

Dr. Bangalore:
Absolutely. I think there is a lot we are learning about this disease process. We covered a lot of ground today, but before we close, are there any additional comments or takeaway messages that you would like to share with our audience?

Dr. Taub:
If there is one mantra that I can instill with our audience, it's "go as low as you can go" in terms of LDL cholesterol for our secondary prevention patients and our high-risk patients.

Dr. Bangalore:
That was great. I completely agree, Dr. Taub. And as we come to the end of today's program, I want to thank you for helping us better understand how we can maintain and even improve continuity of cardiovascular care for this high-risk patient population. Dr. Taub, it was great speaking with you today. Thank you.

Dr. Taub:
Thank you for a great discussion.

Announcer:
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