Cholesterol Management in Primary Care

- Aspirin when appropriate
- Blood pressure control
- Cholesterol management
- Smoking cessation

Healthy Hearts for Oklahoma (H2O)
The Oklahoma Cooperative for AHRQ's EvidenceNOW
ADVANCING HEART HEALTH IN PRIMARY CARE

This document was produced by the National Resource Center for Academic Detailing (NaRCAD), supported by a grant from the Agency for Healthcare Research and Quality. These are general recommendations only; specific clinical decisions should be made by the treating physician based on an individual patient’s clinical condition.
Authors: Jennifer Lewey, MD, Stephen Braun, Michael Fischer, MD, MS, Arielle Mather, MPH.
Manage cholesterol aggressively for patients at highest risk of atherosclerotic cardiovascular disease (ASCVD)³

Patients at highest risk should be prescribed statins unless contraindicated.

<table>
<thead>
<tr>
<th>High Risk Groups</th>
<th>High-intensity statin</th>
<th>Moderate-intensity statin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior ASCVD</td>
<td>≤ 75 y</td>
<td>&gt; 75 y</td>
</tr>
<tr>
<td>LDL-C ≥ 190mg/dL</td>
<td>YES</td>
<td>If not a candidate for high-intensity statin</td>
</tr>
<tr>
<td>Diabetes</td>
<td>≥ 7.5%</td>
<td>&lt; 7.5%</td>
</tr>
<tr>
<td>LDL-C 70-189mg/dL, Age 40-75 y</td>
<td>Estimated 10-y ASCVD risk</td>
<td>Estimated 10-y ASCVD risk</td>
</tr>
<tr>
<td>ASCVD risk ≥ 7.5%</td>
<td>Either high or moderate intensity (based on clinical factors)</td>
<td></td>
</tr>
</tbody>
</table>

Intensity level definitions for commonly used statins³

<table>
<thead>
<tr>
<th>High-intensity statins</th>
<th>Moderate-intensity statins</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower LDL by ≥ 50%</td>
<td>Lower LDL by 30-50%</td>
</tr>
<tr>
<td>Atorvastatin 40-80 mg</td>
<td>Atorvastatin 10-20 mg</td>
</tr>
<tr>
<td>Rosuvastatin 20-40 mg</td>
<td>Rosuvastatin 5-10 mg</td>
</tr>
<tr>
<td></td>
<td>Simvastatin 20-40 mg</td>
</tr>
<tr>
<td></td>
<td>Pravastatin 40-80 mg</td>
</tr>
</tbody>
</table>

Statin benefits for patients with coronary artery disease¹,²

Reduction in absolute risk of death 16%
Reduction in all major cardiovascular events 20%
Prescribing statins for primary prevention based on CV risk

The 2013 ACC/AHA ASCVD risk calculator is the most recent tool for assessing patients’ risk of CV endpoints. While prior guidelines focused on LDL targeting, the ASCVD approach uses patient risk to guide treatment. The calculator incorporates race into the risk assessment, and outcomes are “hard” CV endpoints that patients care about.3

Several other validated tools can be used to identify patients most likely to benefit from cholesterol treatment.4,5,6

For interactive calculators, up-to-date statistics, and more information on this initiative, visit our website: http://ophic.ouhsc.edu/rpr

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- **Framingham Risk Score**
  - (ATP-III calculator)
  - Uses risk factors of age, sex, lipids, hypertension, and smoking.

- **Framingham Risk Score**
  - (Global CVD)
  - + Diabetes mellitus

- **Reynolds Risk Score**
  - + C-reactive protein (CRP)
  - + Family history

Lifestyle modification remains a critical component of health promotion and ASCVD risk reduction, both prior to and in concert with the use of cholesterol-lowering drug therapies.
Determining treatment based on ASCVD risk score

Non-statins for cholesterol treatment

Ezetimibe lowers LDL, but has limited hard endpoint data. Reserve its use for patients unable to take a statin.

PCSK9 inhibitors are injectable agents that reduce LDL dramatically, but their role is not yet clear. Statins should remain the first choice.

References