2014 Update in Medicine
Update in Cholesterol Management

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October 31, 2014
2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults

Endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation, American Pharmacists Association, American Society for Preventive Cardiology, Association of Black Cardiologists, Preventive Cardiovascular Nurses Association, and WomenHeart: The National Coalition for Women with Heart Disease

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Key Points

• Encourage adherence to a heart-healthy lifestyle.
• Statin therapy is recommended for adults in groups demonstrated to benefit.
• Statins have an acceptable margin of safety when used in properly selected individuals and appropriately monitored.
• Engage in a clinician-patient discussion before initiating statin therapy, especially for primary prevention.
Key Points (cont.)

• Use the newly developed Pooled Cohort Equations for estimating 10-year ASCVD risk (40-75 yo).
• [http://clincalc.com/Cardiology/ASCVD/PooledCohort.aspx](http://clincalc.com/Cardiology/ASCVD/PooledCohort.aspx)
• Initiate the appropriate intensity of statin therapy to reduce ASCVD risk.
• Evidence is inadequate to support treatment to specific LDL-C or non-HDL-C treatment goals.
• Regularly monitor patients for adherence to lifestyle and appropriate intensity of statin therapy.
New Perspective on LDL-C & Non–HDL-C

• Lack of RCT evidence to support titration of drug therapy to specific LDL-C and/or non–HDL-C goals
• Strong evidence that appropriate intensity of statin therapy should be used to reduce ASCVD risk in those most likely to benefit
• Quantitative comparison of statin benefits with statin risk
• Nonstatin therapies – did not provide ASCVD risk reduction benefits or safety profiles comparable to statin therapy
4 Statin Benefit Groups

• Clinical ASCVD*
• LDL-C ≥190 mg/dL, Age ≥21 years
• Primary prevention – Diabetes: Age 40-75 years, LDL-C 70-189 mg/dL
• Primary prevention - No Diabetes†: ≥7.5%‡ 10-year ASCVD risk, Age 40-75 years, LDL-C 70-189 mg/dL

*Atherosclerotic cardiovascular disease
†Requires risk discussion between clinician and patient before statin initiation
‡Statin therapy may be considered if risk decision is uncertain after use of ASCVD risk calculator
RISK ASSESSMENT
Heart-healthy lifestyle

Screen adults age ≥20 every 5 years

Clinical ASCVD?
  yes → Age ≤75?
    yes → High-intensity statin
    no → Moderate-intensity statin
  no → LDL-C ≥190 mg/dL?
    yes → High-intensity statin
    no → Estimated 10-year ASCVD risk ≥7.5%?
      yes → High-intensity statin
      no → Moderate-intensity statin
  Diabetes and age 40–75
    yes → Estimated 10-year ASCVD risk ≥7.5%?
      yes → High-intensity statin
      no → Moderate-intensity statin
    no → Age 40–75? (no diabetes)
      yes → ESTIMATE 10-year ASCVD risk every 5 years using Pooled Cohort Equations
tools.cardiosource.org/ASCVD-Risk-Estimator
        10-year risk <5% → Consider moderate-intensity statin
        10-year risk 5%–7.5% → Consider high-or moderate-intensity statin
        10-year risk ≥7.5% → Consider high-intensity statin
      no → Consider additional factors
      Shared decision on statin use
        yes → to statin
          Emphasize lifestyle
          Initiate statin
          Monitor adherence
          Manage other risk factors
        no → to statin
          Emphasize lifestyle and monitor
          Manage other risk factors

TREATMENT
Lifestyle change for all patients
  • Heart-healthy diet to manage LDL-C and, if necessary, BP (DASH, Mediterranean, or cardiac diet)
  • Physical activity: moderate- to vigorous-intensity activity totaling 150 min/week (about 30 min/day)
  • Weight management
  • Smoking cessation

Statin therapy
  • Do not prescribe if patient is pregnant or lactating
  • See CPM for drug interaction cautions

Moderate-intensity statin — Daily dose lowers LDL-C on average by approximately 30% to 50%. Individual responses may vary.
  • Atorvastatin 10 (20) mg
  • Simvastatin 20 mg–40 mg
  • Pravastatin 40 (80) mg
  • Lovastatin 40 mg
  • Fluvastatin XL 80 mg
  • Fluvastatin 40 mg bid
  • Pitavastatin 2 mg–4 mg
  • Rosuvastatin (5) 10 mg

High-intensity statin — Daily dose lowers LDL-C on average by approximately 50% or more. Individual responses may vary.
  • Atorvastatin (40)–80 mg
  • Rosuvastatin 20 (40) mg

Additional factors / shared decision making
Prior to initiating statin therapy, discuss with patient:
  • Additional CV risk factors (LDL-C ≥160 mg/dl, family history, lifetime risk, CKD, ABI, hs-CRP, CAC score)
  • Potential for adverse effects and drug interactions
  • Role of lifestyle change
  • Management of other risk factors
  • Risk of pregnancy
  • Patient preferences
# Intensity of Statin Therapy

Table 5. High- Moderate- and Low-Intensity Statin Therapy (Used in the RCTs reviewed by the Expert Panel)*

<table>
<thead>
<tr>
<th>High-Intensity Statin Therapy</th>
<th>Moderate-Intensity Statin Therapy</th>
<th>Low-Intensity Statin Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily dose lowers LDL–C on average, by approximately ≥50%</td>
<td>Daily dose lowers LDL–C on average, by approximately 30% to &lt;50%</td>
<td>Daily dose lowers LDL–C on average, by &lt;30%</td>
</tr>
</tbody>
</table>

**Atorvastatin (40†)–80 mg**  
**Rosuvastatin 20 (40) mg**

**Atorvastatin 10 (20) mg**  
**Rosuvastatin (5) 10 mg**  
**Simvastatin 20–40 mg‡**  
**Pravastatin 40 (80) mg**  
**Lovastatin 40 mg**  
**Fluvastatin XL 80 mg**  
**Fluvastatin 40 mg bid**  
**Pitavastatin 2–4 mg**

**Simvastatin 10 mg**  
**Pravastatin 10–20 mg**  
**Lovastatin 20 mg**  
**Fluvastatin 20–40 mg**  
**Pitavastatin 1 mg**

*Individual responses to statin therapy varied in the RCTs and should be expected to vary in clinical practice. There might be a biologic basis for a less-than-average response.†Evidence from 1 RCT only: down-titration if unable to tolerate atorvastatin 80 mg in IDEAL (Pedersen et al).‡Although simvastatin 80 mg was evaluated in RCTs, initiation of simvastatin 80 mg or titration to 80 mg is not recommended by the FDA due to the increased risk of myopathy, including rhabdomyolysis.
Beware of Drug Interactions with these Higher Doses of Statins!!!!

- **Atorvastatin and simvastatin** (>90% metabolism hepatic cytochrome P450 (CYP) 3A4):
  - 44 Major, 166 moderate, and 73 minor drug interactions
- **Resuvastatin** (10% hepatic cytochrome P450 2C9):
  - 27 major, 166 moderate, and 28 minor drug interactions
- **Pravastatin** (minimal metabolism by CYP3A4, CYP2C8, or CYP2C9):
  - 11 major, 132 moderate and 4 minor drug interactions
Statin Management

• Check FLP 6 weeks after initiating statin or after any change and repeat annually:
  
  • If LDL-C above 100, re-emphasize lifestyle changes, assure medication compliance.
  
  • If LDL-C remains above 100, consider increasing statin dose/strength (rosuvastatin may be more effective than atorvastatin) or adding ezetamibe for patients at higher risk
  
  • Consider cardiology referral if ongoing statin intolerance or persistently elevated LDL-C
Pooled Cohort Risk Assessment Equations
Predicts 10-year risk for a first atherosclerotic cardiovascular disease (ASCVD) event

Risk Factors for ASCVD

Gender
- Male
- Female

Age
59 years

Race
African American

Systolic BP
140 mmHg

Receiving treatment for high blood pressure (if SBP > 120 mmHg)
- No
- Yes

Diabetes
- No
- Yes

Smoker
- No
- Yes

Total Cholesterol
180 mg/dL

HDL Cholesterol
40 mg/dL
## ACC Pooled Cohort Risk Calculator

**ASCVD Risk Estimator**

All fields are required to compute ASCVD risk.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
<td>20-79</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HDL - Cholesterol (mg/dL)</th>
<th>Total Cholesterol (mg/dL)</th>
<th>Treatment for Hypertension</th>
<th>Systolic Blood Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-100</td>
<td>130-320</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

*Intended for use if there is not ASCVD and the LDL-cholesterol is <190 mg/dL.

**Optimal risk factors include: Total cholesterol of 170 mg/dL, HDL-cholesterol of 50 mg/dL, Systolic BP of 110 mm Hg, Not taking medications for hypertension, Not a diabetic, Not a smoker
## Risk Calculator

### Filling in the numbers...

<table>
<thead>
<tr>
<th>Estimator</th>
<th>Clinicians</th>
<th>Patients</th>
<th>About</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASCVD Risk Estimator</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>10-Year ASCVD Risk</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>Lifetime ASCVD Risk</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>50% calculated risk</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>5% risk with optimal risk factors</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Recommendation Based On Calculation

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
<th>Systolic Blood Pressure</th>
<th>Smoker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>45</td>
<td>White</td>
<td>135</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

**Gender**
- **Male**
- **Female**

**Age**
- 45

**Race**
- **White**
- **African American**
- **Other**

**Systolic Blood Pressure**
- 135

**Smoker**
- Yes
- No

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**Intended for use if there is not ASCVD and the LDL-cholesterol is <190 mg/dL**

**Optimal risk factors include:** Total cholesterol of 170 mg/dL, HDL-cholesterol of 50 mg/dL, Systolic BP of 110 mm Hg, Not taking medications for hypertension, Not a diabetic, Not a smoker

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**Intermountain Heart Institute**

**Intermountain Medical Center**
Based on the data entered (assuming no clinical ASCVD and LDL-C 70-189 mg/dL):

- Gender: Male
- Age: 45
- Race: White/Other
- Total Cholesterol: 280
- HDL-Cholesterol: 29
- Systolic Blood Pressure: 135
- Hypertension Treatment: No
- Diabetes: No
- Smoker: No

Moderate to High-Intensity Statin Recommended

Before initiating statin therapy, it is reasonable for clinicians and patients to engage in a discussion which considers the potential for ASCVD risk reduction benefits and for adverse effects, for drug-drug interactions, and patient preferences for treatment. (IIa C)

Adults 40 to 75 years of age with LDL-C 70 to 189 mg/dL with no diabetes and estimated 10-year ASCVD risk ≥7.5% should be treated with moderate to high-intensity statin therapy. (I A)

In individuals for whom after quantitative risk assessment a risk-based treatment decision is uncertain, additional factors may be considered to inform treatment decision making. These factors may include primary LDL-C ≥160 mg/dL or other evidence of genetic hyperlipidemias, family history of premature ASCVD with onset <55 years of age in a first degree male relative or <65 years of age in a first degree female relative, high-sensitivity C-reactive protein ≥2 mg/L, CAC score ≥300 Agatston units or ≥75 percentile for age, sex, and ethnicity, ankle-brachial index <0.9, or elevated lifetime risk of ASCVD. Additional factors may be identified in the future. (IIb C)

Lifestyle Recommendations

AHA/ACC guidelines stress the importance of lifestyle modifications to lower cardiovascular disease risk. This includes eating a heart-healthy diet, regular aerobic exercises, maintenance of desirable body weight and avoidance of tobacco products.
# Patient References

- Understanding My Cardiovascular Risk
- Diet and Physical Activity Recommendations
- Weight Management Recommendations
- Blood Cholesterol Management Recommendations
- Groups that Benefit from Statin Therapy
- Common Cardiovascular Terms
The Cholesterol Management Development Team, under the guidance of Intermountain’s Primary Care and Cardiovascular Clinical Programs, developed this care process model (CPM) to guide the effective, consistent management of cholesterol for patients across the Intermountain system. This CPM is based on the 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk and the 2013 ACC/AHA Guideline on Lifestyle Management to Reduce Cardiovascular Risk.

▶ Why Focus ON CHOLESTEROL MANAGEMENT?

- More than 30% of U.S. adults have high LDL cholesterol. Of these, about half are being treated for it.
- High cholesterol is a leading risk factor for atherosclerotic cardiovascular disease (ASCVD), heart attack, and stroke.
- New guidelines published in 2013 by a joint task force of the American College of Cardiology and the American Heart Association (ACC/AHA) provides higher quality randomized controlled (RCT) evidence for cholesterol-lowering drug therapy to reduce ASCVD risk.

▶ Key points from the 2013 ACC/AHA guidelines

- Lifestyle modification remains the foundation of ASCVD risk reduction. Heart-healthy lifestyle habits are recommended for all patients, whether or not they are on statin therapy.
- "Treat to target" is out — now the goal is lowering ASCVD risk. Current RCT data do not support titration of drug therapy to specific LDL-C and non-HDL-C goals. Strong evidence supports appropriate intensity of statin therapy to reduce ASCVD risk in those most likely to benefit.
- Four groups of individuals are identified as most likely to benefit from statin therapy. These include patients with clinical ASCVD, with LDL-C ≥190 mg/dL, with diabetes, LDL-C 70–189 mg/dL, and age 40–75, and without diabetes, LDL-C 70–189 mg/dL, age 40–75, and calculated ASCVD risk of ≥7.5%. The algorithm on page 2 illustrates this list.
- A new pooled-cohort risk calculator (available online) evaluates 10-year and lifetime risk of ASCVD and more accurately identifies higher-risk patients who may benefit from statin therapy.
- A shared decision on statin therapy is recommended for primary prevention in patients at lower risk but who have additional risk factors.

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▶ MEASUREMENT & GOALS

As a result of implementing this CPM, Intermountain aims to:
- Impacts Intermountain’s support for the 2013 ACC/AHA guidelines.
- Educate physicians on these guidelines and make the guidelines easy to use.
- Increase appropriate use of statins.

Taken together, these goals are designed to assist Intermountain in reducing the rate of atherosclerotic cardiovascular disease associated with dyslipidemia.
ALGORITHM: ASSESSING AND MANAGING CHOLESTEROL LEVELS AND ASCVD RISK

Heart-healthy lifestyle habits for all patients are the foundation of ASCVD risk reduction (a)

Screen adults age ≥20 years
with full lipoprotein panel (fasting preferred) once every 5 years

> CLINICAL ASCVD
Clinical ASCVD is defined as one or more of the following:
- Acute coronary syndrome
- History of MI
- Stable or unstable angina
- Coronary or other arterial revascularization
- Atherosclerotic stroke
- Atheroembolic TIA
- Atherosclerotic peripheral artery disease
- Abdominal aortic aneurysm

Treatment fundamentals for patients with clinical ASCVD
A — Aspirin/antiplatelet therapy
B — Blood pressure control
C — Cholesterol control and Cigarette smoking cessation
D — Diet and weight management and Diabetes and blood glucose control
E — Exercise
(a) Heart-healthy lifestyle habits for all patients

The 2013 AHA/ACC Lifestyle Management Guidelines recommend the following lifestyle habits. See page 4 for details.

- Heart-healthy diet: to manage LDL cholesterol and, if necessary, blood pressure (Mediterranean or DASH diet)
- Physical activity: Moderate to vigorous intensity physical activity totaling 150 minutes per week (about 30 minutes most days)
- Tobacco cessation: Quit all tobacco products and avoid second-hand smoke
- Weight management: Reach and maintain a normal weight

(b) Statin Therapy

Do not prescribe if patient is pregnant or lactating

High-intensity statin therapy

(For patients with clinical ASCVD and age <75, LDL-C >190, diabetes and age 40 to 75 with other risk factors, or >75% 10-yr ASCVD risk)

Daily dose lowers LDL-C on average by approximately 50% or more*

- Atorvastatin (40) – 80 mg
- Rosuvastatin (20) – 80 mg

Moderate-intensity statin therapy

(For patients with clinical ASCVD and age >75, diabetes and age 40 to 75 without other risk factors, or 3% – 7.5%, 10-yr ASCVD risk)

Daily dose lowers LDL-C on average by approximately 30% to 50%*

- Atorvastatin 10 (20) mg
- Simvastatin 20 mg – 40 mg
- Pravastatin 40 (80) mg
- Lovastatin 40 mg
- Fluvastatin 40 mg bid
- Pitavastatin 2 mg – 4 mg
- Rosuvastatin (10) 10 mg

Low-intensity statin therapy

(For patients with <5% 10-yr ASCVD risk and other risk factors)

Daily dose lowers LDL-C on average by up to 30%*

- Pravastatin 10 mg – 20 mg
- Lovastatin 20 mg
- Simvastatin 10 mg
- Fluvastatin 20 mg – 40 mg
- Pitavastatin 1 mg

Notes: Boldface type indicates preferred drug. Prior to initiating drug therapy, evaluate patient for secondary causes of dyslipidemia, which include diabetes, hypothyroidism, obesity, liver disease, renal failure, or drugs that increase LDL-C and decrease HDL-C (propionates, anabolic steroids, and corticosteroids). Beware of drug interactions with atorvastatin (80 mg) and simvastatin (40 mg), including clarithromycin, erythromycin, amiodarone, calcium channel blockers, or fluconazole.

*Individual responses to statin therapy should be expected to vary in clinical practice. There may be a biologic basis for less-than-average response.

Evidence from 1 RCT only: down-litigation if unable to tolerate atorvastatin 80 mg in IDEAL (Pedersen et al).

Although simvastatin 80 mg was evaluated in RCTs, initiation of simvastatin 80 mg or titration to 80 mg is not recommended by the FDA due to the increased risk of myopathy, including rhabdomyolysis.

(c) Primary prevention in patients without diabetes and with LDL-C 70–189 mg/dL

- Emphasize adherence to a heart-healthy lifestyle
- Check fasting lipid profile every 5 years
- For patients age 40 to 75 years, estimate 10-year ASCVD risk every 5 years beginning at age 40, and choose appropriate statin therapy
  - Use the Pooled Cohort Equations available at https://tools.cardiolog.org/ASCVD-Risk-Estimator/
  - For patients <40 years or >75 years and LDL-C <150 mg/dL, consider additional factors and make shared decision on statin use

(d) Additional factors

When unsure whether to prescribe a statin, consider these additional ASCVD risk factors:

- Primary LDL-C >160 mg/dL
- Family history of premature ASCVD
- High (<60%) lifetime ASCVD risk calculated using Pooled Cohort Equation
- Chronic kidney disease stage 3 or 4
- Coronary artery calcium (CAC) score >300 Agatston units or >20th percentile for age and sex
- Ankle brachial index (ABI) <0.9
- F-sCRP >2.0 mg/L
- Metabolic syndrome or prediabetes

(e) Shared decision on statin use

Prior to initiating statin therapy, discuss with patient:

- Potential for ASCVD risk reduction benefit from statin therapy
- Potential for adverse effects and drug interactions from statin therapy
- Role of therapeutic lifestyle change
- Management of other risk factors such as blood pressure, diabetes, and abdominal obesity
- Risk of pregnancy
- Patient preferences

(continues on next page)
HEART-HEALTHY LIFESTYLE MANAGEMENT

Lifestyle modification is the foundation for ASCVD risk reduction efforts

Lifestyle modification is a critical component of health promotion and ASCVD risk reduction — both prior to and in conjunction with the use of cholesterol-lowering drug therapies. The recommendations below combine ACC/AHA Guidelines of Lifestyle Management to Reduce Cardiovascular Risk and the AHA Diet and Lifestyle Recommendations.

<table>
<thead>
<tr>
<th>Lifestyle modification</th>
<th>Recommendation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adhere to a heart-healthy eating pattern</td>
<td>Adhere all patients to consume a diet that:</td>
<td>Achieve this pattern by following plans such as the Mediterranean diet pattern.</td>
</tr>
<tr>
<td></td>
<td>• is rich in vegetables, fruits, and whole grains</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• includes low fat dairy products, poultry, fish, legumes, nonstarchy vegetables, oils, and nuts</td>
<td>Adapt dietary pattern to appropriate calorie requirements, personal and cultural food preferences, and nutrition therapy for other conditions including diabetes.</td>
</tr>
<tr>
<td></td>
<td>• limits sweets, sugar-sweetened beverages, and red meats</td>
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<tr>
<td></td>
<td>Advise adults who would benefit from LDL-C lowering to:</td>
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</tr>
<tr>
<td></td>
<td>• Consume &lt;6% of daily calories from saturated fat</td>
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<tr>
<td></td>
<td>• Reduce percent of calories from trans fat to 1% or less</td>
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<tr>
<td></td>
<td>Advise adults who would benefit from BP lowering to:</td>
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<tr>
<td></td>
<td>• Consume &lt;2,400 mg of sodium/day</td>
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<tr>
<td></td>
<td>• Further reduction of sodium Intake to &lt;1,500 mg/day is associated with even greater reduction in SBP</td>
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<tr>
<td></td>
<td>• Even if the desired daily sodium Intake is not achieved, a reduction of 1,000 mg/day from baseline shows benefit (the effect of sodium reduction is greater in black people, older people, and people with diabetes, metabolic syndrome, or CVD.4)</td>
<td></td>
</tr>
<tr>
<td>Increase physical activity</td>
<td>Advise all patients to:</td>
<td>This recommendation is consistent with Intermountain’s lifestyle and Weight Management CPM.</td>
</tr>
<tr>
<td></td>
<td>• Engage in regular aerobic physical activity, such as brisk walking, at least 30 minutes/week (30 minutes/day, most days of the week) (5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Substantial epidemologic evidence indicates there is a dose-dependent inverse relationship between levels of physical activity and rates of CVD. (6)</td>
<td></td>
</tr>
<tr>
<td>Quit tobacco</td>
<td>Complete tobacco cessation.</td>
<td></td>
</tr>
<tr>
<td>Maintain a normal weight</td>
<td>Weight loss and maintenance are critical for prevention and control of CVD risk factors.</td>
<td></td>
</tr>
<tr>
<td>Limit alcohol consumption</td>
<td>Limit alcohol to ≤2 drinks/day in most men or ≤1 drink/day in women and lighter-weight persons. One drink = 12 oz beer, 5 oz wine, or 1.5 oz hard alcohol.</td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES

For a list of guidelines and references used in the development of this CPM, go to the Cardiovascular Clinical Program page on IntermountainHealthcare.net or Intermountainphysician.org.
Yes: Patient is at High-Risk of ASCVD

Implement treatment recommendations:
• A – Aspirin / Antiplatelet therapy
• B – Blood pressure control
• C – Cholesterol control / Cigarette smoking cessation
• D – Diet and weight management / Diabetes and blood sugar control
• E – Exercise
Primary Prevention
(*LDL-C 70-189mg/dL, no known ASCVD, No DM*)

• Estimate 10-y ASCVD risk every 5 years beginning at 20 y. Using ACC/AHA Pooled Cohort Risk Equation

• For ages 20-40 years, 75-79 use lifetime risk estimate of >40% to encourage use of statins

• For people with < 7.5% 10-y ASCVD risk or borderline indications for statins, consider other risk factors such as coronary calcification (patients > 50 yo, score > 300, high intensity statin; 100-300 moderate intensity; 1-100 low intensity statin), hsCRP, FH, ABI <0.9
DIABETES AND AGE 20–39 OR OVER 75: INTERMOUNTAIN RECOMMENDATIONS

• For non-pregnant patients age 20–40 If lifetime ASCVD risk is 30-40%, a low-intensity statin is recommended

• If lifetime ASCVD risk is >40%, a moderate-intensity statin is recommended

• For patients age 75 and older, a moderate-intensity statin is recommended.
Patient Education—ACC CardioSmart Explorer

CardioSmart
American College of Cardiology
powered by medmovie.com®

Normal
- Left Blood Flow
- Right Blood Flow
- Four Chambers

Vascular
- Heart Attack

Muscular
- Heart Failure

Valves
- Mitral Valve Prolapse

Electrical
- Atrial Fibrillation
- Ventricular Fibrillation

Intermountain Heart Institute
Intermountain Medical Center
Thank You