LIPID MODIFICATION FOR PRIMARY PREVENTION OF CVD

QRISK®2: ≥20% (consider if 10-20%) over 10 years

Use QRISK2 if ≤ 84 years & for T2DM

- QRISK2 may underestimate CVD risk in certain groups (refer to supporting information)

T1DM

- consider statin for all T1DM
- offer statin if: >40 years; nephropathy: other CVD risk factors; diabetes >10 years)

≥ 85 years

- consider comorbidities, polypharmacy general frailty & life expectancy
- consider statin if smoker or raised BP

CKD

eGFR <60ml/min/1.73m^2 &/or albuminuria)

Baseline blood tests & clinical assessment:

BP, smoking status, alcohol consumption, weight/BMI, non- fasting lipid profile, HbA1c, renal function/eGFR, LFTs, TFTs, CK if unexplained muscle pain +/- statin

Refer to specialist if:

- TC >9.0 mmol/litre
- non-HDL-C >7.5 mmol/litre
- TG persistently >10 mmol/litre
- urgent referral if TG > 20 mmol/litre not due to alcohol or poor glycaemic control

Familial Hypercholesterolaemia

Consider & investigate possibility of FH if TC >7.5 mmol/litre & family history of premature CHD

- Patients with FH should be offered specialist referral to confirm diagnosis & initiate cascade testing
- Refer to supporting information for treatment of FH

Interventions and lifestyle measures

- Treat comorbidities & identify and manage secondary causes of dyslipidaemia
- Lifestyle modification & otimise management of modifiable CVD risk factors: BP, smoking cessation, weight, cardioprotective diet, physical activity, alcohol, HbA1c

Lifestyle measures ineffective or inappropriate

Reassess QRISK2 where appropriate to reconfirm ≥20% (consider if 10-20%) over 10 years

Statin Declined

- Record choice in notes
- Reassess CVD risk at later date.

Informed discussion about the risks/benefits of statins

Patient decision aid available to support discussions & explain risks/benefits of statins for different CVD % risks

Statin Intolerance

- Refer to supporting information for LFT & CK monitoring & action
- Stop statin & try again when symptoms resolve to check if statin related
- Consider lower dose of atorvastatin
- Consider change to simvastatin or pravastatin (consider rosuvastatin as 4th line option)
- Treat with max tolerated dose - any statin at any dose will ↓CVD risk
- Do NOT offer coenzyme Q10 or vitamin D to increase adherence
- Seek specialist advice if high risk of CVD & intolerant to 4 statins.

Statin contraindicated/not tolerated/ineffective

- **Do NOT routinely offer** fibrates
- **DO NOT OFFER**
  - omega-3 fatty acid compounds
  - nicotinic acid
  - bile acid sequestrant
- **DO NOT OFFER COMBINATION of any of the above WITH statin**

OFFER ATORVASTATIN 20mg daily

Use lower dose if potential drug interaction – see SPC for prescribing information

- Advise about adverse effects and interactions
- Repeat lipid profile & LFTs in 3 months

NO SPECIFIC LIPID TARGET: aim for >40% reduction in non HDL-C

If <40% reduction in non HDL-C:

- Optimise adherence and dose timing
- Optimise diet and lifestyle measures
  - Consider increasing dose if judged as higher risk due to comorbidities/risk score/clinical judgement
  - If eGFR <30ml/min/1.73m^2 agree increasing dose with renal specialist

Annual medication review

- discuss adherence, lifestyle & address CVD risk factors
- consider non-fasting non-HDL-C test to inform discussion