Lipid Treatment Guidance

Guidance: Lipid management for patients with CVD and risks of CVD
(up to and inc. 84 years exc. frailty / women of child bearing age <55years)

West Yorkshire and Harrogate HEALTHY HEARTS

Further details provided on West Yorkshire Healthy Hearts website

Shared Decision Making
Outline the risks and benefits of statin/lipid lowering therapies, taking into account lifestyle modifications, comorbidities, polypharmacy, general frailty and life expectancy.

Lifestyle
Lifestyle to be considered fundamental to this guidance. Lifestyle helps to reduce future CVD risk. Statins are effective at reducing cholesterol. Both are important.

Show patients the QRISK3 risk assessment tool and/or JBS3 risk calculator

Primary Prevention

CKD 3 and above (regardless of cholesterol level or risk of CVD) QRISK2 >10% 10 year Cardiovascular Risk Diabetes Type 1 who are older than 40 or nephropathy or had T1DM for more than 10 years or other CVD risk factors

Usually - Atorvastatin 40mg

Sometimes Atorvastatin 20mg
Scenarios: Concerns about dosage / Potential sensitivity of those of South Asian/East Asian

Secondary Prevention

Established CHD/IHD/MI Ischemic Stroke & TIA, PAD.

Recommended - Atorvastatin 80mg

Statin-associated muscle symptoms are one of the principal reasons for statin non-adherence and/or discontinuation. However, not all patients with such symptoms, if statins related, should lead to a label of 'statin intolerance'. If recommended statin treatment is contraindicated or not tolerated - follow **Statin Intolerance Algorithm** for advice.

TARGETS - Aim for LDL <1.8 or non-HDL<2.5 with up-titration to 80mg Atorvastatin if required

Before starting statins take full lipid profile - Total / HDL / Non-HDL / Triglycerides (A fasting sample is not needed) Check ALTs at baseline and at 3 months. No further checks required after starting statin unless clinical concern (e.g. liver disease) Show patients targets and progress to help behaviour change.

Those intolerant to Atorvastatin
Initiate one month of **Rosuvastatin** 5 mg once daily (doubled to 10 mg daily for primary prevention on repeat prescription after one month if no reported side effects) For secondary prevention up to 20 mg once daily, dose to be increased gradually at intervals of at least 4 weeks

Primary Prevention

If statin intolerance **confirmed** / Contraindicated
→ **Ezetimibe** 10mg/**Bempedoic Acid** 180 mg OD combination if Ezetimibe does not control non-HDL

If statin does not achieve cholesterol reduction
→ **Add Ezetimibe** 10mg OD

If non-HDL not to target consider referral to specialist lipid management clinic

Please consider **Familial hypercholesterolaemia** (FH) and **Hyperlipidaemia** in anyone with a Total Cholesterol >7.5mmol/L or LDL >4.9 mmol/ - Talk to patients to get family history. Familial hypercholesterolaemia affects c.1 in 325. NHS Long Term Plan commitment to improving detection of FH from 7% to 25% by 2024. See pathway for further information.

Secondary Prevention

If statin intolerance **confirmed** / Contraindicated
→ **Ezetimibe** 10mg/**Bempedoic Acid** 180 mg OD combination if Ezetimibe does not control non-HDL

If statin does not achieve cholesterol reduction
→ **Add Ezetimibe** 10mg OD

If non-HDL-C > 2.5mmol/L after 3 months consider **injectable therapies**. Arrange a fasting blood test for LDL-C

Initiation of **Inclisiran** if LDL-C ≥ 2.6mmol/L

OR

Referral to specialist lipid service for **PCSK9i** if LDL-C >3.5 mmol/L

This is a local version of the National Guidance: www.england.nhs.uk/aac/publication/summary-of-national-guidance-for-lipid-management
Further information on Cholesterol can be found at: www.westyorkshireandharrogatehealthyhearts.co.uk
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