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SPECIAL ARTICLE

Practical recommendations for the management of cardiovascular risk associated with atherogenic dyslipidemia, with special attention to residual risk. Spanish adaptation of a European Consensus of Experts☆

Atherogenic Dyslipemia Working Group of the Spanish Society of Atherosclerosis and the European Expert Group◊

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Statin;
Fenofibrate;
Fenofibrate-statin combination therapy

Abstract This document has discussed clinical approaches to managing cardiovascular risk in clinical practice, with special focus on residual cardiovascular risk associated with lipid abnormalities, especially atherogenic dyslipidaemia (AD).

A simplified definition of AD was proposed to enhance understanding of this condition, its prevalence and its impact on cardiovascular risk. AD can be defined by high fasting triglyceride levels (≥2.3 mmol/l/≥200 mg/dl) and low high-density lipoprotein cholesterol (HDL-c) levels (≤1.0/40 and ≤1.3 mmol/l/50 mg/dl in men and women, respectively) in statin-treated patients at high cardiovascular risk. The use of a single marker for the diagnosis and treatment of AD, such as non-HDL-c, was advocated. Interventions including lifestyle optimisation and low density lipoprotein (LDL) lowering therapy with statins (±ezetimibe) are recommended by experts. Treatment of residual AD can be performed with the addition of fenofibrate, since it can improve the complete lipoprotein profile and reduce the risk of cardiovascular events in patients with AD. Others clinical condictions in which fenofibrate may be prescribed include patients with very high TGs (≥5.6 mmol/l/500 mg/dl), patients who are intolerant or resistant to statins, and patients with AD and at high cardiovascular risk. The fenofibrate-statin combination was considered by the experts to benefit from a favourable benefit-risk profile.

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◊ The names of the components of the Atherogenic Dyslipemia Working Group of the Spanish Society of Atherosclerosis and the European Expert Group are related in Annex.

In conclusion, cardiovascular experts adopt a multifaceted approach to the prevention of atherosclerotic cardiovascular disease, with lifestyle optimisation, LDL-lowering therapy and treatment of AD with fenofibrate routinely used to help reduce a patient's overall cardiovascular risk.

PALABRAS CLAVE
Dislipemia aterogénica;
Riesgo cardiovascular;
Riesgo cardiovascular residual;
Estatina;
Fenofibrato;
Terapia combinada estatina-fenofibrato

Recomendaciones prácticas para el manejo del riesgo cardiovascular asociado a la dislipemia aterogénica, con especial atención al riesgo residual. Adaptación española de un Consenso Europeo de Expertos

Resumen El documento incluye los aspectos clínicos para abordar el riego cardiovascular en la práctica clínica, con especial atención en el riesgo cardiovascular residual asociado a anomalías lipídicas, especialmente dislipemia aterogénica (DA).

Se propone una definición simplificada de DA para mejorar la comprensión del problema, su prevalencia y su impacto en el riesgo cardiovascular. La DA puede ser definida por aumento de los niveles de triglicéridos ($\geq$ 2,3 mmol/l/$\geq$ 200 mg/dl) y descenso de cHDL ($\leq$ 1,0/40 y $\leq$ 1,3 mmol/l/50 mg/dl en hombres y mujeres, respectivamente) en pacientes con alto riesgo cardiovascular en tratamiento con estatinas. Se recomienda el empleo de un marcador simple para el diagnóstico y tratamiento de la DA, tal como es el colesterol-no-HDL. Para los expertos, la intervención terapéutica incluye optimización del estilo de vida y fármacos hipocolesterolemiantes (estatinas $\pm$ ezetimiba). El tratamiento de la DA residual se puede completar con la adición de fenofibrato, al objeto de mejorar el perfíl lipídico completo y reducir el riesgo de accidentes cardiovasculares en los pacientes con DA. Otras situaciones clínicas en las que se puede prescribir fenofibrato incluyen los pacientes con hipertrigliceridemias elevadas ($\geq$ 5,6 mmol/l/500 mg/dl), enfermos con intolerancia o resistencia a las estatinas, y pacientes con alto riesgo cardiovascular que presentan DA. Los expertos consideran que la combinación estatina-fenofibrato muestra un perfil favorable riesgo-beneficio.

En conclusión, los expertos proponen un manejo multifactorial para la prevención de la enfermedad cardiovascular aterosclerótica mediante optimización del estilo de vida, tratamiento para reducir el cLDL y tratamiento de la DA con adición de fenofibrato de forma rutinaria, al objeto de reducir el riesgo cardiovascular global del paciente.

Introduction

Treatment with statins is critical to cardiovascular (CV) disease prevention due to their capacity to reduce low-density lipoprotein cholesterol (LDL-C) levels. A decrease in cardiovascular events has also recently been demonstrated when an additional LDL-C reduction is achieved, either through high doses of statins or the combination of a statin with another cholesterol-lowering drug such as ezetimibe, as shown by the IMPROVE-IT study.[1] However, statins do not eliminate the residual risk deriving from other lipid abnormalities, such as hypertriglyceridaemia and/or low levels of high-density lipoprotein cholesterol (HDL-C), which can cause additional cardiovascular events.

A consensus document representing the opinion of European cardiovascular disease experts has recently been published. It describes the importance of atherogenic dyslipidaemia (AD) in contributing to sustained elevated CV risk, as well as the role of the statin-fenofibrate combination in offering a comprehensive approach to dyslipidaemia treatment in the face of AD, when the patient also requires supplementary cholesterol-lowering treatment due to elevated CV risk.[2]

The aim of this article is to summarise the opinion of these experts concerning the clinical decisions that govern CV risk management when specifically faced with this type of residual risk associated with atherogenic dyslipidaemia in clinical practice.

Atherogenic dyslipidaemia and residual cardiovascular risk

Numerous factors contribute to CV risk, whether non-lipid related (age, gender, smoking, alcohol, diabetes mellitus, obesity, hypertension) or lipid-related (increased LDL-C, elevated triglyceride levels and or low HDL-C). Statins, in combination with an improved lifestyle, reduce the rate of CV events in many patients. Nevertheless, it is common for patients to still suffer cardiovascular events, particularly