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CLINICAL UP-DATE

Cardiovascular news 2013/2014☆

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Abstract During 2013 and the first months of 2014, numerous studies have been published in the cardiovascular field. New guidelines have appeared for managing arterial hypertension and reducing cardiovascular risk by lowering cholesterol levels. New data have emerged on the considerable lipid-lowering efficacy of monoclonal antibodies against PCSK-9, in contrast, however, to the clinical trials directed toward raising HDL-cholesterol with nicotinic acid, which have not shown a reduction in the rate of cardiovascular complications. In the field of hypertension, neither stent placement in patients with renovascular hypertension nor sympathetic denervation in patients with resistant hypertension has been shown to be effective in reducing blood pressure. In terms of antithrombotic treatment, the pharmacogenetic tests do not seem useful for maintaining patients anticoagulated with warfarin within the therapeutic range for longer periods. Moreover, there is increasing evidence that, for patients with coronary artery disease and atrial fibrillation, antiplatelet therapy adds no benefit to anticoagulation therapy and is associated with a greater risk of bleeding. Lastly, a Mediterranean diet could prevent the onset of diabetes, while bariatric surgery could be a reasonable option for improving the disease in patients with obesity. Many of these studies have immediate practice applications in daily clinical practice.
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Novedades cardiovasculares 2013/2014

Resumen Durante el año 2013 y los primeros meses de 2014 se han publicado numerosos estudios relevantes en el campo cardiovascular. Han aparecido nuevas guías para el manejo de la hipertensión arterial y para reducir el riesgo cardiovascular descendiendo el colesterol. También han aparecido nuevos datos sobre la gran eficacia hipolipidemiante de los anticuerpos monoclonales frente a PCSK-9, decepcionando, sin embargo, los ensayos clínicos dirigidos a elevar el colesterol-HDL con ácido nicotínico, los cuales no han demostrado una reducción de la tasa de complicaciones cardiovasculares. Tampoco en el campo de la hipertensión, la colocación de un *stent* en pacientes con hipertensión renovascular, o la denervación simpática en pacientes con hipertensión resistente, han demostrado ser eficaces para reducir la presión arterial. Con relación al tratamiento antitrombótico, los test farmacogenéticos no parecen útiles para mantener más tiempo en rango terapéutico a los pacientes anticoagulados con warfarina. A su vez, cada vez existen más evidencias de que en pacientes con enfermedad coronaria y fibrilación auricular, la antiagregación no añade beneficio a la anticoagulación y se asocia con un mayor riesgo de sangrado. Por último, una dieta de tipo mediterráneo podría prevenir la aparición de diabetes, mientras que la cirugía bariátrica podría ser una opción razonable para mejorar la enfermedad en pacientes obesos. Muchos de estos estudios tienen una aplicación práctica inmediata en el trabajo clínico diario.
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In recent decades, we have witnessed a progressive reduction in cardiovascular mortality in developed countries. Coronary mortality in Spain from 1988 to 2005 declined by 40%[1] as the result of a populational reduction in cardiovascular risk factors, better prevention and better treatment of already established disease. The reduction in cardiovascular mortality has contributed the most to increasing the life expectancy in industrialized countries in general and in Spain in particular.[2] The reduction is the result of continuous developments in this area, mainly those related to primary and secondary prevention of the disease. Keeping abreast of these developments requires health professionals to continuously update their knowledge and skills, which is one of the commitments of the Cardiovascular Risk Workgroup of the Spanish Society of Internal Medicine. Every year[3,4] the Group meeting reserves a round table to conduct an update on issues of cardiovascular risk. In this article, we present the lectures from the meeting held on May 2014 in Alicante.

Risk guidelines (Dr. José Ignacio Cuende)

Last year, several publications emerged in the field of cardiovascular risk assessment that merit discussion. The new American treatment guidelines for blood cholesterol[5] have undoubtedly sparked an interesting debate. These guidelines, sponsored by the American Heart Association and the American College of Cardiology, base their recommendations on the strict reading of clinical trials, recommendations on which not all of the scientific community agree. These guidelines were published simultaneously with the guidelines for the quantification of cardiovascular risk,[6] lifestyle management[7] and excess weight and obesity control in adults.[8] They were published shortly after the guidelines of the International Atherosclerosis Society[9] and 2 years after the European Guidelines for the Management of Dyslipidemia.[10] The American guidelines for managing cholesterol use a new cardiovascular risk assessment scale presented in the risk quantification guidelines.[7] These guidelines establish a new equation for measuring atherosclerotic cardiovascular risk based on pooled data from several American cohort studies (Framingham, ARIC, CARDIA, etc.), creating a pooled cohort, measuring the risk of cardiovascular morbidity and mortality at 10 years and establishing a cutoff of 7.5% as an indicator of high risk. The guidelines consider the white non-Hispanic and black African-American races, as well as the variables of sex, age (40–79 years), diabetes, smoking, systolic blood pressure (BP), treatment for BP, total cholesterol and HDL-cholesterol.

The guidelines also answer clinical questions about the usefulness of other risk factors and markers and the use of lifelong risk. If there are questions about patient management based on measured risk, we can consider the patient's family history of early cardiovascular events, ultrasensitive C-reactive protein levels and the quantification of coronary calcium and the ankle-brachial index. The routine quantification of the intima-media thickness is not recommended. The guidelines establish that there is no clear evidence compared with other markers such as apoB, renal function, microalbuminuria and cardiopulmonary condition. Moreover, if a patient of between 20 and 59 years of age is not determined to be high risk with the new scale, we can apply the risk quantification at 30 years or throughout life with the educational intention of changing lifestyles and promoting adherence to medical advice but not as a guideline for clinical decision making.

After the publication of the American guidelines on risk quantification and cholesterol treatment, two articles

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