

Dyslipidemia



How Low Should We Go? A Review of Current Lipid Guidelines

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KEYWORDS

- Hypercholesterolemia • Dyslipidemia • Lipid guidelines
- Statin and nonstatin therapy • Atherosclerotic cardiovascular disease

KEY POINTS

- Though most guidelines recommend fasting lipid panels, a nonfasting test is appropriate for many patients and its convenience may increase compliance with testing.
- The 2013 the American College of Cardiology (ACC) and American Heart Association cholesterol management guideline represents a paradigm shift away from the treat-to-target approach for lowering low-density lipoprotein cholesterol embodied in the 2001 Adult Treatment Panel III guideline to a cardiac risk-based approach.
- Four groups of patients are now identified as being appropriate for statin therapy and the intensity of dosing is based on an assessment of medication benefit versus risk using a global cardiovascular risk calculator.
- The 2016 ACC expert consensus document filled a gap in the 2013 guideline by providing guidance for the use of nonstatin lipid-lowering drugs in patients whose response to statins is suboptimal or who do not tolerate statins.
- Gaps in the 2013 guideline relating to lipid management in children and patients with chronic kidney disease are covered in other recent guidelines, but evidence-based guidance for treating the very elderly is limited.

INTRODUCTION

Despite advances in treatment, atherosclerotic cardiovascular disease (ASCVD) remains the leading cause of death in the United States¹ (**Fig. 1**).

The management of hypercholesterolemia has been a cornerstone in the fight against ASCVD. For more than a decade before 2013, clinicians relied on the National

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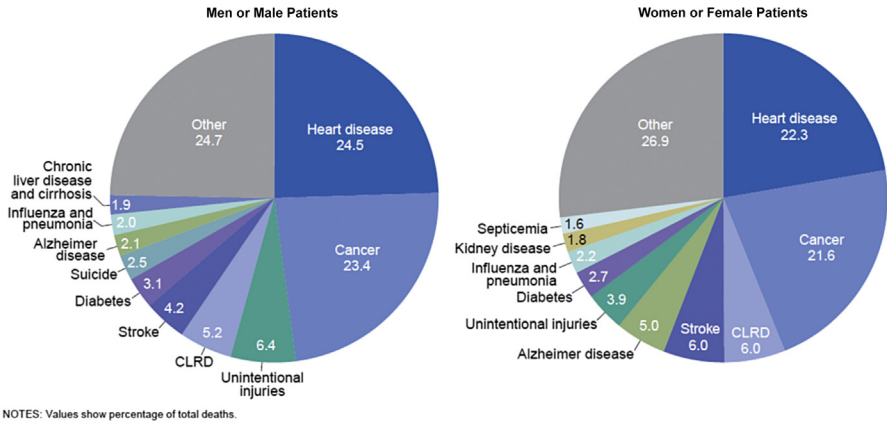


Fig. 1. Percent distribution of the 10 leading causes of death, by sex: United States, 2014. CLRD, chronic lower respiratory disease. (From CDC/National Center for Health Statistics 2016. leading causes of death. Available at: <http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm>. Accessed May 24, 2017; and Courtesy of NCHS, National Vital Statistics System, Mortality.)

Cholesterol Education Program Adult Treatment Panel III (ATP III) guideline for the management of hypercholesterolemia. This guideline was introduced in 2001, fully reported in 2002, and updated in 2004.^{2,3}

In 2013, an expert panel from the American College of Cardiology (ACC) and the American Heart Association (AHA) created a new guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular (CV) risk in adults (2013 ACC/AHA guideline).^{4,5} This guideline, based on a rigorous analysis of evidence, mainly from randomized clinical trials, is focused on using statins to reduce global ASCVD risk. However, because of its focus on statin therapy, it created uncertainty over the role of nonstatin drugs for high-risk patients who either have a less-than-anticipated response to statins or who have statin intolerance. This gap was filled in 2016 by an ACC expert consensus document.⁶

Disconcerting, however, is the gap between the 2013 ACC/AHA guideline and its implementation. A recent survey of primary care (family practice, internal medicine) and specialty (cardiology, endocrinology) practices revealed that “most clinicians do not completely understand the guideline” and are “moving away from lipid testing to document response and adherence to statin therapy.”⁷ A recent analysis of 204 cardiology practices showed that a statin was prescribed for only 62% of patients with diabetes and that prescribing patterns varied widely. Moreover, only 58% of patients had a low-density lipoprotein cholesterol (LDL-C) lower than 100 mg/dL.⁸ These observations indicate a need for improved understanding of current lipid.

This article highlights the laboratory assessment of hyperlipidemia, the salient features of the 2013 ACC/AHA guideline and the 2016 ACC consensus document, and lipid management in special populations not fully addressed in these guidelines. Additional resources of information are provided to assist practitioners and patients in achieving optimal ASCVD risk reduction through lipid control.

Although lifestyle modifications, including diet, physical activity, smoking cessation, and weight and blood pressure control, are necessary adjuncts to pharmacologic therapy in reducing ASCVD risk, these measures are covered in detail in companion 2013 ACC/AHA guidelines and are not discussed in this article.^{9,10}

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