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National Lipid Association Recommendations - Part 2

National Lipid Association Recommendations for Patient-Centered Management of Dyslipidemia: Part 2

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Abstract: An Expert Panel convened by the National Lipid Association previously developed a consensus set of recommendations for the patient-centered management of dyslipidemia in clinical medicine (part 1). These were guided by the principle that reducing elevated levels of atherogenic cholesterol (non–high-density lipoprotein cholesterol and low-density lipoprotein cholesterol) reduces the risk for atherosclerotic cardiovascular disease. This document represents a continuation of the National Lipid Association recommendations developed by a diverse panel of experts who examined the evidence base and provided recommendations regarding the following topics: (1) lifestyle therapies; (2) groups with special considerations, including children and adolescents, women, older patients, certain ethnic and racial groups, patients infected with human immunodeficiency virus, patients with rheumatoid arthritis, and patients with residual risk despite statin and lifestyle therapies; and (3) strategies to improve patient outcomes by increasing adherence and using team-based collaborative care.

Introduction

In 2014, the National Lipid Association (NLA) convened an Expert Panel to develop a consensus set of recommendations for the patient-centered management of dyslipidemia (Part 1).[1] The evidence base used was derived from randomized controlled trials (RCTs), meta-analyses of results from RCTs, and review of results from observational, genetic, metabolic, and mechanistic studies. Based on the totality of evidence, the Part 1 NLA Recommendations for Patient-Centered Management of Dyslipidemia laid out several conclusions and core principles.

1. An elevated level of cholesterol carried by circulating apolipoprotein (apo) B-containing lipoproteins (non-high-density lipoprotein cholesterol [non-HDL-C] and low-density lipoprotein cholesterol [LDL-C], termed *atherogenic cholesterol*) is a root cause of atherosclerosis, the key underlying process contributing to most clinical atherosclerotic cardiovascular disease (ASCVD) events;
2. Reducing elevated levels of atherogenic cholesterol will lower ASCVD risk in proportion to the extent that atherogenic cholesterol is reduced;
3. The intensity of risk-reduction therapy should generally be adjusted to the patient's absolute risk for an ASCVD event;
4. Atherosclerosis is a process that often begins early in life and progresses for decades before resulting in a clinical ASCVD event. Therefore, both intermediate-term and long-term/lifetime risk should be considered when assessing the potential benefits and hazards of risk-reduction therapies;
5. For patients in whom lipid-lowering drug therapy is indicated, statin treatment is the primary modality for reducing ASCVD risk;
6. Treatment goals and periodic monitoring of atherogenic cholesterol levels (non-HDL-C and LDL-C) are important tools in the implementation of a successful treatment strategy. These aid the clinician in assessing the adequacy of treatment and facilitate active participation by the patient through feedback and reinforcement of the beneficial effects of lifestyle and pharmaceutical therapies; and
7. Non-lipid ASCVD risk factors should also be managed appropriately, particularly high blood pressure, cigarette smoking, and diabetes mellitus.

The NLA Part 1 Recommendations emphasize the importance of taking a *patient-centered* approach in counseling patients about the benefits and hazards of lifestyle and drug therapies. Using the principle of shared decision making, the patient should be an active participant in the process, engaging with the clinician in a dialogue about the objectives and potential benefits of therapy, as well as risks, side effects, and costs. The initial step is a determination of the patient's risk for an ASCVD event (Table 1).[1] Lifestyle counseling is a key element of preventive efforts at all levels of risk, and dietary adjuncts may be used to enhance atherogenic cholesterol reduction. If lifestyle therapies, including dietary adjuncts, are insufficient to achieve desired levels of atherogenic cholesterol, evidence-based drug therapy, particularly moderate- to high-intensity statin therapy should be considered. If goal levels of atherogenic cholesterol are not achieved with maximally tolerated statin therapy, combining a statin with a second (and sometimes a third) agent may be considered for selected patients. Alternative strategies may be needed for patients who are statin intolerant, or who prefer not to use statin therapy. Lastly, regular patient and lipid follow-up is warranted to assess adherence and adequacy of the atherogenic cholesterol responses to therapy.

NLA Part 2 recommendations

The creation of the NLA Part 2 Recommendations for Patient-Centered Management of Dyslipidemia was intended to expand upon the NLA Part 1 Recommendations in areas where clinicians may desire additional guidance, particularly where the evidence base is less robust or is