Be Prepared With Answers About the New Cholesterol Guidelines

You'll hear buzz about the **new cholesterol guidelines that bring back some emphasis on LDL and promote even more individualization**.

Think about LDL to guide non-statin use...but ONLY for the highest-risk SECONDARY prevention patients, such as those with multiple CV events OR a single CV event plus additional CV risks (diabetes, smoking, etc).

Experts have landed on 70 mg/dL as the threshold to consider adding a non-statin...AFTER verifying adherence to statins and lifestyle changes. The change is based on more data that "lower is better" in these patients.

Continue to use a high-intensity statin (atorvastatin 80 mg, etc) for very high-risk patients. Then consider a stepped approach if needed.

Add ezetimibe first. It prevents one CV event for every 50 acute coronary syndrome patients treated for about 7 years...is well tolerated...and costs about $360/yr for the generic.

If LDL is still above 70 mg/dL, weigh pros and cons of injectable *Praluent* (alirocumab) or *Repatha* (evolocumab). Adding one of these PCSK9 inhibitors to a statin in patients with CV disease and other CV risks prevents about one CV event for every 70 patients treated for 2 to 3 yrs.

But *Repatha* costs about $4,150/yr...*Praluent* about $13,400/yr. Payer contracts may result in similar costs for either med.

Don't routinely add ezetimibe or a PCSK9 inhibitor for lower-risk patients with CV disease. Help them stick to their statin instead.

And don't start a bile acid sequestrant, fibrate, or niacin...these aren't shown to improve CV outcomes when added to a statin.

Further individualize treatment...for those ages 40 to 75 withOUT CV disease. Continue using the Am Coll of Cardiology/Am Heart Assn CV risk estimator as a starting point for shared decision making about statins.

Prescribe a high-intensity statin if 10-year CV risk is 20% or higher, since this level of risk is similar to having CV disease.

But if CV risk is 7.5% to 19.9%, look for "risk enhancers" BEFORE starting a statin. For example, consider family history, kidney disease, etc...or risk markers such as elevated coronary artery calcium (CAC) score.

In these PRIMARY prevention patients with additional CV risks, discuss starting a moderate-intensity statin (atorvastatin 20 mg, etc).

Continue using a statin in patients with diabetes ages 40 to 75.

Listen to *PL Voices* for insights from a guideline author. See our chart, *2018 ACC/AHA Cholesterol Guidelines*, to get the full scoop.

Key References:

-J Am Coll Cardiol Published online Nov 8, 2018; doi:10.1016/j.jacc.2018.11.003
-J Am Coll Cardiol Published online Nov 3, 2018; doi:10.1016/j.jacc.2018.11.004

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-J Am Coll Cardiol Published online Nov 3, 2018; doi:10.1016/j.jacc.2018.11.005
-Medication pricing by Elsevier, accessed Dec 2018

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