

INITIAL CONSIDERATIONS

Measure non-fasting full lipid profile (TC, HDL-C, non-HDL-C, triglycerides) and HbA_{1c} as part of an initial baseline assessment. Consider secondary causes of hyperlipidaemia and manage as needed. Ensure appropriate baseline and follow-up tests as detailed in the guideline. Measure BMI, identify and exclude people with contraindications/drug interactions. If non-fasting triglyceride above 4.5 mmol/l see the guideline text.

PRIMARY PREVENTION

Consider statin therapy for adults who do not have established CVD but fall into the categories below. Use QRISK (a) assessment tool where appropriate (see Primary prevention risk assessment in the guideline).



Identify and address all modifiable risk factors—smoking, diet, obesity, alcohol intake, physical activity, blood pressure, and HbA_{1c}.

Consider additional risk factors, if present, together with QRISK score (raised for FH, severe mental illness, taking medicines that cause dyslipidaemia, systemic inflammatory disorder (e.g. SLE), impaired fasting glycaemia, recent change in risk factors).

PRIMARY PREVENTION

If lifestyle modification is ineffective or inappropriate offer statin treatment: **atorvastatin 20 mg OD**

- Measure full lipid profile again after 3 months (non-fasting)
- High-intensity statin treatment should achieve reduction of non-HDL-C >40% from baseline. If not achieved after 3 months:
 - discuss treatment adherence, timing of dose, diet, and lifestyle
 - If at higher risk based on comorbidities, risk score or clinical judgement—see Additional risk factors consider increasing the dose every 2–3 months up to a maximum dose of atorvastatin 80 mg OD*
 - for how to increase in people with CKD, see the section Special patient populations

- If patients on a high-intensity statin have side effects, offer a lower dose or an alternative statin (see Statin intensity table)
- If maximum tolerated dose of statin does not achieve non-HDL-C reduction >40% of baseline value after 3 months, consider adding ezetimibe 10 mg OD
- If recommended statin treatment is contraindicated or not tolerated:
 - see AAC Statin Intolerance Algorithm^(A) for advice regarding adverse effects
 - ezetimibe 10-mg monotherapy may be considered. Assess response after 3 months
 - ezetimibe 10-mg/rosuvastatin acid 180-mg combination may be considered when ezetimibe alone does not control non-HDL-C/LDL-C well enough (NICE TA694)

If non-HDL-C reduction remains <40% of baseline despite maximal tolerated lipid-lowering therapy (including people with intolerance and contraindications) consider referral to specialist lipid management clinic according to local arrangements

SEVERE HYPERLIPIDAEMIA

FFTC ≥7.5 mmol/l and/or LDL-C ≥8.9 mmol/l and/or non-HDL-C ≥5.9 mmol/l, a personal or family history of confirmed CVD (≥40 years) and with no secondary causes, suspect FH (possible heterozygous FH). Do not use QRISK risk assessment tool.

DIAGNOSIS AND REFERRAL

Take fasting blood for repeat lipid profile to measure LDL-C. Use the Simon Broome or Dutch Lipid Clinic Network criteria to make a clinical diagnosis of FH. Refer to lipid clinic for further assessment if clinical diagnosis of FH or if TC ≥7.5 mmol/l and/or LDL-C ≥4.5 mmol/l and/or non-HDL-C ≥2.5 mmol/l or fasting triglycerides ≥1.0 mmol/l (regardless of family history).

TREATMENT TARGETS IN FH

If clinical diagnosis of FH and/or other risk factors present, follow the recommended treatment management pathway for primary or secondary prevention as for non-FH, BUT aim to achieve at least a 50% reduction of LDL-C (or non-fasting non-HDL-C) from baseline.

Consider specialist referral for further treatment and/or consideration of PCSK9 therapy (B):

- they are assessed to be at very high risk of a coronary event*
 - or therapy is not tolerated
 - or LDL-C remains ≥5 mmol/l (primary prevention)
 - or LDL-C remains ≥2.5 mmol/l (secondary prevention) despite maximal tolerated statin and ezetimibe therapy.
- *defined as any of the following:
- established CVD
 - two or more other CVD risk factors

SECONDARY PREVENTION

Offer statin therapy to adults with CVD, not including angina, previous MI, heart transplantation, stroke, or TIA, or angiodysplasia, peripheral arterial disease. Do not delay statin treatment if a person has acute coronary syndrome. Take a lipid profile on admission (within 24 hours).

Identify and address all modifiable risk factors—smoking, diet, obesity, alcohol intake, physical activity, blood pressure, and HbA_{1c}.

SECONDARY PREVENTION

Do not delay statin treatment in secondary prevention while managing modifiable risk factors. Prescribe a high-intensity statin: **atorvastatin 80 mg OD**. Use a lower dose of atorvastatin if there is a potential drug interaction, high risk of an exacerbating adverse effect, or patient preference. (see atorvastatin 20 mg, 40 mg people with CVD and non-HDL-C ≥2.5)

- Measure full lipid profile again after 3 months (non-fasting)
 - High-intensity statin treatment should achieve reduction of non-HDL-C >40% from baseline. If not achieved after 3 months:
 - discuss treatment adherence, timing of dose, diet, and lifestyle measures
 - If started on less than atorvastatin 80 mg and the person is judged to be at higher risk (based on comorbidities, risk score or clinical judgement—see Additional risk factors), consider increasing to 80 mg atorvastatin. For how to increase in people with CKD see Special patient populations
 - If non-HDL-C baseline value is not available*, consider target non-HDL-C <2.5 mmol/l (approximately equivalent to LDL-C <1.8 mmol/l) as recommended by Joint British Societies
 - If patients on a high-intensity statin have side effects, offer a lower dose or an alternative statin (see Extent of lipid lowering with available therapies)
- *this scenario is not covered by NICE Q&A10

If maximum tolerated dose of statin does not control non-HDL-C/LDL-C well enough after 3 months, confirm statin adherence then consider the following options based on shared decision making^(A) with the patient. See the full guideline for information to support shared decision making.

If recommended statin treatment is contraindicated or not tolerated, follow the AAC Statin Intolerance Algorithm^(A) for advice regarding adverse effects

If statin intolerance is confirmed, consider:

- ezetimibe 10 mg monotherapy. Assess response after 3 months (TA695)
- ezetimibe 10 mg/rosuvastatin acid 180-mg combination when ezetimibe alone does not control non-HDL-C sufficiently (NICE TA694)

Ezetimibe 10-mg daily (NICE TA695) Reassess after 3 months. If non-HDL-C remains ≥2.5 mmol/l, consider injectable therapies, arrange a fasting blood test, and assess eligibility (TA718)

If non-HDL-C remains ≥2.5 mmol/l despite other lipid lowering therapies, consider injectable therapies—arrange a fasting blood test and assess eligibility criteria (TA694–694, TA718)

Injectable therapies^(A)
If non-HDL-C ≥2.5 mmol/l, arrange fasting blood test to measure LDL-C to assess eligibility:

- inclisiran**—if fasting LDL-C ≥2.6 mmol/l, despite maximum tolerated lipid lowering therapy (TA718)
- or PCSK9i**—see below (Extent of lipid lowering with available therapies for LDL-C thresholds (TA719–4)

 If eligibility criteria are not met, consider **ezetimibe 10 mg daily** (if not previously considered). Inclisiran and PCSK9i should not be prescribed concurrently.

(A) England: the shared decision making intolerance pathway

BM=body mass index; CVD=cardiovascular disease; CKD=chronic kidney disease; CVD=cardiovascular disease; eGFR=estimated glomerular filtration rate; FH=familial hypercholesterolaemia; HbA_{1c}=haemoglobin A_{1c}; HDL-C=high-density lipoprotein cholesterol; LDL-C=low-density lipoprotein cholesterol; MI=acute myocardial infarction; OD=once daily; PCSK9i=proprotein convertase subtilisin kexin 9 inhibitor; SLE=systemic lupus erythematosus; TC=total cholesterol; TIA=transient ischaemic attack.

New Lipid Guidelines Summary

Joel J. Heidelbaugh

A red circular graphic with a gradient, appearing as a semi-circle or a partial circle, located to the right of the author's name.

New Lipid Guidelines Summary:

Lipids, An Issue of Endocrinology and Metabolism Clinics of North America Donald A. Smith, 2014-12-26 This issue of Endocrinology and Metabolism Clinics devoted to Lipids is edited by Dr Donald A Smith Articles in this issue include Advanced Lipoprotein Testing Improving Cardiovascular Risk Assessment Coronary calcium scor and CT coronary imaging Understanding HDL Statin Strategies for Maximizing Public Health benefits and harms Cellular Cholesterol Regulation SREBP and miRNA Mediterranean Diet the best diet for CV protection Pediatric Lipidology An Earlier Approach Newer LDL lowering Therapies and Statin Combination Therapies

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Clinical Lipid Management Jennifer G. Robinson, MD, 2023-10-11 Presents the newest thinking and data needed for clinicians to reduce atherosclerotic cardiovascular disease ASCVD risk This book provides detailed evidence based guidance for treating cholesterol to reduce ASCVD with a focus on recent ACC AHA guidelines an overview of evidence based treatment of other risk factors the management of genetic and acquired lipid disorders and complete efficacy and safety information on all available lipid lowering agents including clinical trial data and FDA approved labeling

Management of Cardiovascular Disease in Women Hanna Z. Mieszczanska, Gladys P. Velarde, 2014-03-24 Cardiovascular disease is the leading cause of death in women in the US with more women dying from heart disease than men Women may have different presentation from men and often need a different approach to diagnosis and treatment There are also unique topics of management of heart disease in women including issues during pregnancy lactation and menopause Many different health care providers as well as cardiologists are involved in treating these patients A manual reviewing diagnosis and treatment of cardiac disease in women would help providers without specific cardiology training to deliver care with greater efficiency A practical and comprehensive guide geared towards these providers would be a highly practical and valuable resource that would be

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Informing Clinical Practice in Nephrology Mohsen El Kossi, Arif Khwaja, Meguid El Nahas, 2015-04-01 Historically clinical decisions in renal medicine have been challenged by the scarce availability of robust supportive evidence Not only are the number of randomized controlled trials RCTs in Nephrology the third lowest amongst the medical specialties but in many instances the trials themselves are of poor quality In addition practice has been further influenced by extrapolation from the outcomes of general population clinical trials which exclude renal patients The difference between the ideal trial participant and real complex cases encountered in daily practice is well recognized and further compounded in renal patients with complex pathophysiology this ultimately makes decision making in this subset of patients a real challenge Recently there has been a growing interest in conducting well designed RCTs in different areas of renal medicine However though clinical guidelines are helpful in providing the clinicians with a frame of best available evidence for a clinical condition it denies the unique nature of each individual patient This book offers a thorough and critical appraisal and evaluation of the key published clinical trials that have shaped current practice in nephrology dialysis and transplantation It will help the practicing physician close the gap between the inflexible and generalized nature of clinical guidelines and the day to day clinical decision making for individual patients It will provide the clinician with the tools required to investigate and extract the appropriate guidance to apply to individual cases in daily practice Moreover it will help improve the ability of junior colleagues to appraise available evidence in a systematic way when there is lack of local guidelines or when the guidelines are difficult to apply due to logistic constraints or barriers Lastly this book will serve as a reference for key clinical trials in different areas of renal medicine together with literature and authors views of these trials and their impact on changing practice

Clinical Lipidology - E-Book Christie M. Ballantyne, 2023-01-06 Part of the renowned Braunwald family of references Clinical Lipidology A Companion to Braunwald's Heart Disease provides today's clinicians with clear authoritative guidance on the therapeutic management of patients with high cholesterol levels and other atherogenic lipid disorders An invaluable resource for cardiologists lipidologists endocrinologists and internal medicine physicians this one stop reference covers everything from basic science and the pathogenesis of atherothrombotic disease to risk assessment and the latest therapy options Now fully updated from cover to cover the 3rd Edition offers unparalleled coverage of lipidology in an accessible and user friendly manner Thoroughly covers the assessment diagnosis and treatment of patients with elevated levels of lipids and lipoproteins including all the latest research based recommendations therapeutic breakthroughs and related clinical advances Presents the latest data on clinical

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inhibitors a new treatment for lowering cholesterol in the blood *Wong's Essentials of Pediatric Nursing - E-Book* Marilyn J. Hockenberry, David Wilson, Cheryl C Rodgers, 2021-03-05 Selected for Doody's Core Titles 2024 with Essential Purchase designation in Pediatrics As the 1 title in the pediatric nursing market for over 40 years Wong's Essentials of Pediatric Nursing 11th Edition continues to leverage its trademark developmental approach as it equips readers with the very latest research and guidelines for treating children today The text utilizes a highly readable writing style and encourages a whole body approach beginning with child development and health promotion to better understand the later chapters on specific health problems This new eleventh edition also features Next Generation NCLEX style case studies and questions a new chapter covering all systems cancers additional case studies within the nursing care plans and updated and expanded evidence based content throughout to best reflect the latest standards and trends impacting pediatric nursing care today Developmental approach clearly identifies developmental tasks and influences at each stage of a child's growth Emphasis on wellness features health promotion chapters for each developmental stage of childhood Critical thinking case studies with answers are found throughout the text Quality patient outcomes are highlighted within nursing management discussions for major diseases and disorders Drug alerts draw attention to potential safety issues reflecting QSEN safety initiative Family focus includes a separate family chapter as well as family content and Family Centered Care boxes integrated throughout the text Community Focus boxes provide resources and guidance on caring for children outside the clinical setting Evidence Based Practice boxes focus attention on the application of research and critical thought processes to support and guide the outcomes of nursing care Chapter on complementary alternative therapy cover timely topics to aid in providing complete comprehensive care Nursing care plans provide a model for planning patient care and include rationales that provide the why Research Focus boxes highlight current studies that impact pediatric nursing today Cultural content and Cultural Considerations boxes are integrated throughout the text to draw attention to customs and beliefs of different cultures that influence childcare Atraumatic Care boxes contain techniques for care that minimize pain discomfort or stress Nursing tips offer helpful hints and practical clinical information of a non emergency nature Nursing alerts feature critical information that MUST BE considered in providing care Emergency Treatment sections provide a quick reference in critical situations Nursing care guidelines provide clear step by step instructions for performing specific skills or procedures

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