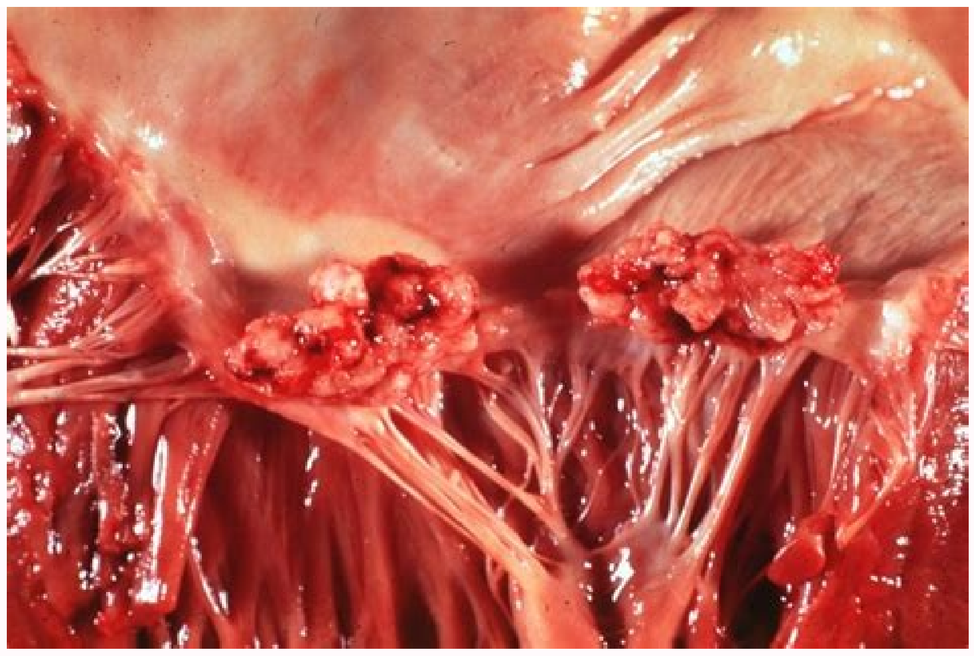
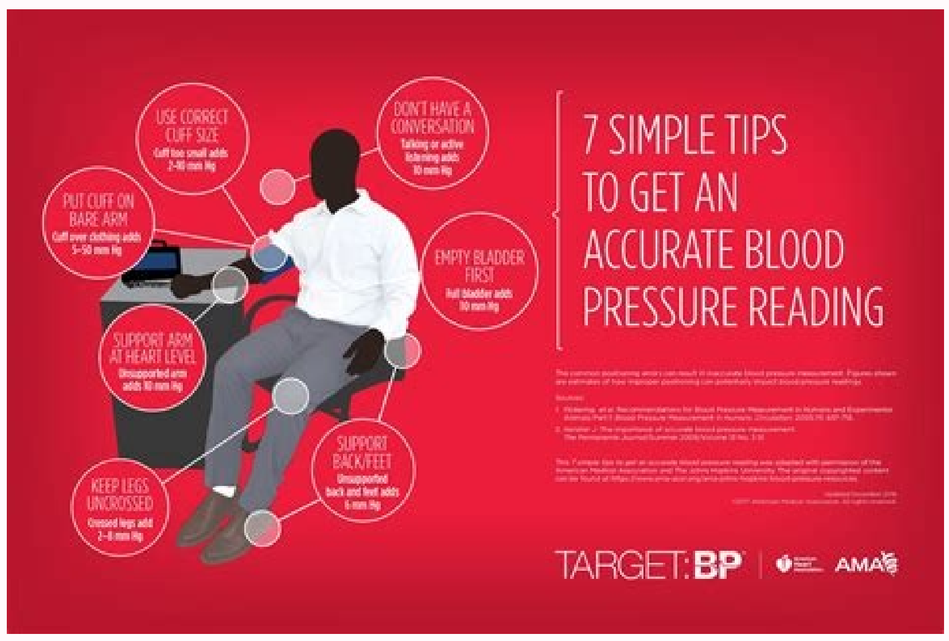
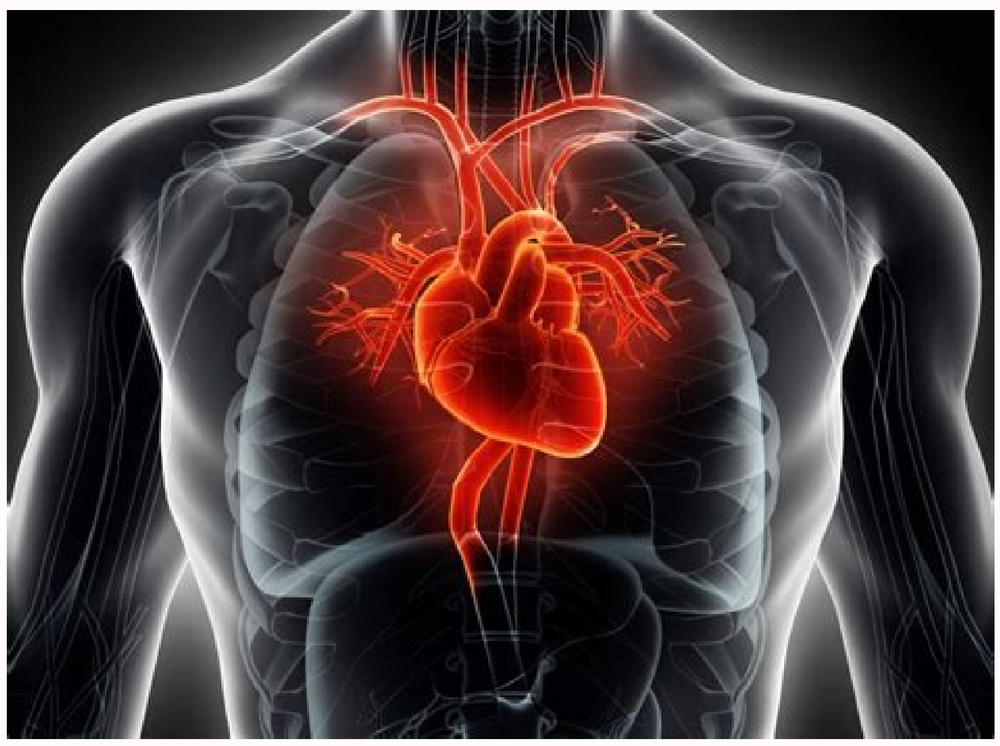
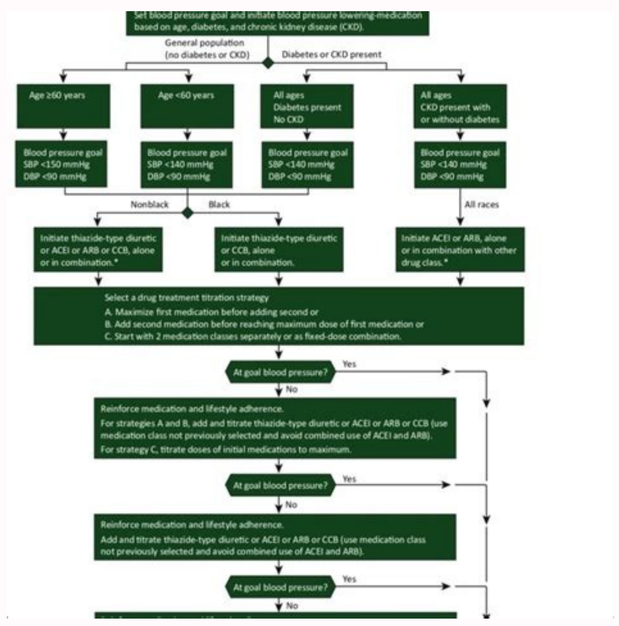
Guideline acc aha 2018









2018 acc/aha guideline on the primary prevention of cardiovascular disease. 2018 acc/aha/hrs guideline on bradycardia. 2018 aha/acc guideline for the management of adults with congenital heart disease. 2018 aha/acc/multisociety cholesterol guideline. Hypertriglyceridemia management according to the 2018 aha/acc guideline. Acc/aha hypertension guideline 2018. Guideline acc/aha 2018. Dyslipidemia guideline acc/aha 2018.

Nov 10, 2018 | Melvyn Rubenfire, MD, FACC Authors: Grundy SM, Stone NJ, Bailey AL, et al. Citation: 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/ APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Practice Guidelines. J Am Coll Cardiol 2018;Nov 10:[Epub ahead of print]. The following are key perspectives from the 2018 multisociety Guideline on the Management of Blood Cholesterol, based on the Top Ten Take Home Messages selected by the Writing Committee. The 2018 guideline emphasizes reducing risk of atherosclerotic cardiovascular disease (ASCVD) through lipid management. It updates the 2013 guideline and emphasizes a more intensive approach based on recent controlled studies and expert consensus. An accompanying review of risk assessment tools to guide decision making for prevention of ASCVD is very helpful (see Lloyd-Jones DM, et al., Special Report on Use of Risk Assessment Tools to Guide Decision-Making in the Primary Prevention of ASCVD. J Am Coll Cardiol 2018;Nov 10:[Epub ahead of print]). I have taken the liberty to utilize the 10 important points selected by the Writing Committee and make comments (italicized) based on other content and my clinical practice and experience. In all individuals, emphasize a heart-healthy lifestyle across the life course. A healthy lifestyle reduces ASCVD risk at all ages. In younger individuals, healthy lifestyle can reduce development of risk factors and is the foundation of ASCVD risk reduction. In young adults 20 to 39 years of age, an assessment of lifetime risk facilitates the clinician–patient risk discussion and emphasizes intensive lifestyle efforts. In all age groups, lifestyle therapy is the primary intervention for metabolic syndrome. Expert Perspective: As with generalized obesity, the lifestyle changes to eliminate one or more of the metabolic syndrome components often need a multidisciplinary effort over long periods of time to prevent recidivism. In patients with clinical ASCVD, reduce low-density lipoprotein cholesterol (LDL-C) with high-intensity statins or maximally tolerated statins to decrease ASCVD risk. Greater LDL-C reductions on statin therapy, leading to lower LDL-C levels, lower significant risk. Use a maximally tolerated statin to reduce LDL-C levels by ≥50%. Expert Perspective: The guideline definition of clinical ASCVD includes stroke, transient ischemic attack (TIA), documented coronary artery disease (CAD) with stable angina, acute coronary syndromes (ACS), coronary or other arterial revascularization, peripheral vascular disease with or without claudication, and aortic aneurysm. While risk estimates for deciding preventive therapies should not include stress testing or cardiac ultrasound, in men and women with a ≥5% 10-year risk for CV events, I would include ASCVD in asymptomatic CAD with ischemia defined by stress electrocardiography (ECG) or stress imaging. In those who are low risk with evidence of ischemia, the addition of a coronary artery calcium (CAC) score would help clarify risk. In very high-risk ASCVD, use an LDL-C threshold of 70 mg/dl (1.8 mmol/L) to consider addition of nonstatins to statins. In very high-risk ASCVD patients, it is reasonable to add ezetimibe to maximally tolerated statin therapy when the LDL-C level remains ≥70 mg/dl (≥1.8 mmol/L). In patients at very high risk whose LDL-C level remains ≥70 mg/dl on maximally tolerated statin and ezetimibe therapy, adding a PCSK9 inhibitor is reasonable, although the long-term safety (>3 years) is uncertain and cost-effectiveness is low at mid-2018 prices. Expert Perspective: Very high risk for future ASCVD events includes a history of multiple major ASCVD events (ACS within 12 months, myocardial infarction, ischemic stroke, peripheral arterial disease defined as claudication with ankle-brachial index [ABI] 2, current smoker, and LDL-C ≥100 mg/dl despite maximally tolerated statin therapy and ezetimibe. These recommendations extend the use of PCSK9 inhibitors to those patients included in the outcome trials who demonstrated LDL-C ‘lower is better’ and safe to very low levels. In patients with severe primary hypercholesterolemia (LDL-C level ≥190 mg/dl [≥4.9 mmol/L]) without calculating 10-year ASCVD risk, begin high-intensity statin therapy. If the LDL-C level remains ≥100 mg/dl, adding ezetimibe is reasonable. If the LDL-C level on statin plus ezetimibe remains ≥100 mg/dl and the patient has multiple factors that increase subsequent risk of ASCVD events, a PCSK9 inhibitor may be considered, although the long-term safety (>3 years) is uncertain and economic value is uncertain at mid-2018 prices. Expert Perspective: Patients with HeFH are approved by the Food and Drug Administration (FDA) and most insurance carriers for PCSK9 inhibitor therapy regardless of presence of ASCVD because of very high risk. Those with HeFH and an LDL-C of 190 mg/dl have a 3-4-fold greater risk of CV events than others at the same LDL-C level and 20-fold greater risk than those with an LDL-C of 130 mg/dl. HeFH is more common than previously thought and needs to be considered in all persons with premature coronary disease and those with elevated LDL-C and family members with premature CAD or high LDL-C. In patients 40 to 75 years of age with diabetes mellitus and an LDL-C level of ≥70 mg/dl, start moderate-intensity statins without calculating 10-year ASCVD risk. In patients with diabetes mellitus at higher risk, especially those with multiple risk factors or those 50 to 75 years of age, it is reasonable to use a high-intensity statin to reduce the LDL-C level by ≥50%. In adults 40 to 75 years of age evaluated for primary ASCVD prevention, have a clinician–patient risk discussion before starting statin therapy. Risk discussion should include a review of major risk factors (e.g., cigarette smoking, elevated blood pressure, LDL-C, hemoglobin A1c [if indicated], and calculated 10-year risk of ASCVD); the presence of risk-enhancing factors (see #8); the potential benefits of lifestyle and statin therapies; the potential for adverse effects and drug–drug interactions; consideration of costs of statin therapy; and patient preferences and values in shared decision-making. Expert Perspective: Primary care physician time constraints often necessitate use of trained nonphysician providers for risk assessment and discussions and referral to lipid or other prevention specialists, particularly for patients with a family history of premature coronary disease and major risk factors. In adults 40 to 75 years of age without diabetes mellitus and with LDL-C levels ≥70 mg/dl (≥1.8 mmol/L), at a 10-year ASCVD risk of ≥7.5%, start a moderate-intensity statin if a discussion of treatment options favors statin therapy. Risk-enhancing factors favor statin therapy (see #8). If risk status is uncertain, consider using CAC to improve specificity (see #9). If statins are indicated, reduce LDL-C levels by ≥30%, and if 10-year risk is ≥20%, reduce LDL-C levels by ≥50%. Expert Perspective: If the patient is considered intermediate risk but there are ≥1 risk-enhancing factors or a high CAC score as in #8 and #9, you can discuss higher intensity statin as an option. In adults 40 to 75 years of age without diabetes mellitus and 10-year risk of 5%-19.9%, risk-enhancing factors favor initiation of statin therapy. Risk-enhancing factors include family history of premature ASCVD; persistently elevated LDL-C levels ≥160 mg/dl (≥4.1 mmol/L); metabolic syndrome; chronic kidney disease; history of preeclampsia or premature menopause (age Expert Perspective: Other risk-enhancing factors include systemic lupus, and radiation therapy for left breast cancer and other radiation therapies where the left main, left anterior descending, and proximal right coronary artery is in the field. In adults 40 to 75 years of age without diabetes mellitus and with LDL-C levels ≥70 mg/dl-89 mg/dl (≥1.8-4.9 mmol/L), at a 10-year ASCVD risk of ≥7.5%-19.9%, if a decision about statin therapy is uncertain, consider measuring CAC. If the CAC score is zero, treatment with statin therapy may be withheld or delayed, except in cigarette smokers, those with diabetes mellitus, and those with a strong family history of premature ASCVD. A CAC score of 1-99 favors statin therapy, especially in those >55 years of age. For any patient, if the CAC score is ≥100 Agatston units or ≥75th percentile, statin therapy is indicated unless otherwise deferred by the outcome of clinician–patient risk discussion. Expert Perspective: Unfortunately, screening using the CAC is patient pay with cost of $75-$350. Considering that it can be performed at less than the cost of an ECG, and that the results are highly impactful, it makes no sense that it is not paid by a third party. CAC has replaced ‘old-fashioned’ expensive testing for ischemia. High CAC scores have been shown to enhance compliance with lifestyle behavior and help patients decide on a long-term treatment strategy in the absence of symptoms. Assess adherence and percentage response to LDL-C–lowering medications and lifestyle changes with repeat lipid measurement 4 to 12 weeks after statin initiation or dose adjustment, repeated every 3 to 12 months as needed. Define responses to lifestyle and statin therapy by percentage reductions in LDL-C levels compared with baseline. In ASCVD patients at very high-risk, triggers for adding nonstatin drugs are defined by threshold LDL-C levels ≥70 mg/dl (≥1.8 mmol/L) on maximal statin therapy (see #3). Clinical Topics: Cardiovascular Care Team, Diabetes and Cardiometabolic Disease, Dyslipidemia, Invasive Cardiovascular Angiography and Intervention, Noninvasive Imaging, Prevention, Lipid Metabolism, Nonstatins, Novel Agents, Statins, Interventions and Imaging, Computed Tomography, Nuclear Imaging, Diet, Exercise Keywords: Atherosclerosis, Body Weight Changes, Cardiac Imaging Techniques, Cholesterol, Cost-Benefit Analysis, Costs and Cost Analysis, Decision Making, Diabetes Mellitus, Diet, Dyslipidemias, Exercise, HIV Infections, Hydroxymethylglutaryl-CoA Reductase Inhibitors, Inflammation, Multidetector Computed Tomography, Life Style, Lipids, Lipoproteins, Mass Screening, Metabolic Syndrome, Motor Activity, Patient Compliance, Pediatrics, Plaque, Atherosclerotic, Primary Prevention, Renal Insufficiency, Chronic, Risk Assessment, Risk Factors, Risk Reduction Behavior, Safety, Secondary Prevention, Value of Life, Vascular Diseases, Women < Back to Listings

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