South London Algorithm for Lipid Management for the Primary and Secondary Prevention of CVD
(Adapted from NICE CG181: Lipid Modifaction July 2014) Approved by SW London Medicines Commissioning Group: 18 Sept 2014 (pending SWL CCG sign off); Review date: Sept 2017

Primary CVD prevention including people with type II diabetes
All patients with a CV risk ≥ 10% without known CVD, or familial hypercholesterolemia

- Calculate CV risk using the QRisk2 risk calculator (for all < 85 years*, including those with type II diabetes)
- If QRisk2 < 10% over the next 10 years
  - Give lifestyle advice; Ensure regular review of CVD risk in line with local guidance
- If QRisk2 ≥ 10%** over next 10 years
  - Reassess CV risk after a trial of lifestyle modification and if QRisk2 remains ≥10% over 10 years OFFER atorvastatin 20mg daily**
    - If there are potential drug interactions or atorvastatin 20mg is contraindicated or not tolerated, consider a lower dose of atorvastatin (or alternative generic agents, such as pravastatin)
  - Identify and address all modifiable risk factors: smoking, diet, obesity, alcohol intake, physical activity, blood pressure** and blood glucose / HbA1c
  - Reinforce lifestyle issues and check adherence to medication
    - There are no specific lipid treatment targets for primary prevention, but if patient is considered higher risk due to the presence of multiple cardiovascular risk factors, consider increasing statin dose if necessary to reduce non-HDL cholesterol by 40% from baseline
  - Once statin therapy has been initiated - repeat lipid profile at 3 months
    - Reinforce lifestyle issues and check adherence to medication
    - Aim to reduce non-HDL cholesterol by 40% from baseline
      - If baseline cholesterol is unknown, as a minimum, patients should be treated to achieve at least a total cholesterol ≤ 5mmol/L and non-HDL cholesterol ≤ 3.8mmol/L
      - Increase statin dose if not achieving adequate reductions in cholesterol (and not already on maximum dose) – seek advice in renal disease
    - Consider referral for specialist advice if patients not achieving a 40% fall in non-HDL cholesterol on maximum tolerated dose of statin

- Routine safety and efficacy monitoring should be undertaken
- Patients should be reviewed annually, with lipid monitoring, to check efficacy and on-going adherence to therapy. Lifestyle issues should be revisited regularly

People with type 1 diabetes
who:
- Are over 40 years old or
- have had type 1 diabetes for more than 10 years or
- have evidence of kidney disease or other CV risk factors

- Reinforce lifestyle issues and check adherence to medication

Acute coronary syndromes and secondary prevention of CVD
All patients with established CVD or atherosclerotic vascular disease

People with chronic kidney disease (CKD)
(eGFR < 60ml/kg/min)

- Initiate atorvastatin 20mg daily***
  - (If potential drug interactions or atorvastatin 20mg is contraindicated or not tolerated, consider a lower dose of atorvastatin or consider an alternative generic agent)

- If statin therapy is contraindicated or not tolerated or not effective, do not offer a fibrate, nicotinic acid or bile acid binder or omega-3 fatty acids to lower CV disease risk.
  People with primary hypercholesterolaemia may be considered for treatment with ezetimibe in line with NICE TA 132

*People ≥ 85years are at high CV risk due to age alone, but consider other CV risk factors, co-morbidities and patient preferences before initiating therapy. ** QRisk2 threshold of 20% applies for the introduction of antihypertensive therapies in people with hypertension. *** If initial statin dose not tolerated – reduce to maximum tolerated dose

Note: This guidance applies to new patients and may also be taken into consideration for those already on statins at their annual review. Patients stable on simvastatin do not need to be switched to atorvastatin

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