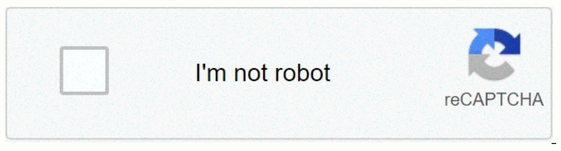

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Dyslipidemia nice guidelines 2014

Thisedition of NICE Bites reflects current NICE guidance (as at November 2020). Please go to NICE to check any recent updates to this instruction. A good bite is a monthly bulletin from the North West Medicines Information Center that summarizes the key prescribing points of NICE tips. NICE Bites No 65, July 2014 includes one topic: Lipid modification (NICE CG181). The covered sectors include cardiovascular risk assessment, lifestyle modification, fat measurement, pharmacological treatment (statin) and monitoring. 1.1.1 For primary prevention of CVD in primary care, use a systematic strategy to identify people who are most likely to be at high risk. [2008, amended 2014] 1.1.2 Prioritise people on the estimate of their CVD risk before a full formal risk assessment. Estimating your CVD risk using CVD risk factors is now recorded in primary care electronic medical records. [2008] 1.1.3 People older than 40 should have their estimate of the risk of CVD checked on an ongoing basis. [2008] 1.1.4 People's preference for full official risk assessment if their 10-year estimated risk of CVD is 10% or more. [2008, amended 2014] 1.1.5 Discuss the process of risk assessment with the person identified as being at risk, including the option of declining any formal risk assessment. [2008] 1.1.6 Does not use opportunistic assessment as the main strategy in primary care to identify CVD risk in unsalited individuals. [2008] 1.1.7 Be aware that all CVD risk assessment tools can provide only an approximate value for CVD risk. Interpreting CVD risk scores should always reflect informed clinical judgment. [2008] 1.1.8 Use of QRISK2 Risk Assessment Tool to Assess CVD Risk for Primary Prevention of CVD in People Up to Age and Including Age 84 Years. [New 2014] 1.1.9 Use a risk assessment tool to assess CVD risk in people with type 1 diabetes. See recommendations 1.3.23, 1.3.24 and 1.3.25 for advice on statin treatment for people with type 1 diabetes. [New 2014] 1.1.10 Use of QRISK2 Risk Assessment Tool to Assess CVD Risk in People with Type 2 Diabetes. [New 2014] 1.1.11 Use a risk assessment tool to assess CVD risk in people with estimated glomerular purification rate (eGFR) of less than 60 ml per minute/1.73 mM and/or albuminuria. These people are at increased risk of CVD. See Recommendation 1.3.27 for advice on statin therapy for people with chronic kidney disease (CKD). [New 2014] People in kidney replacement therapy are outside the scope of this guideline. 1.1.12 Complete as many areas of risk assessment tool as possible. [New 2014] 1.1.13 typically records ethnicity, BMI and early CVD family history in medical records. [2008] 1.1.14 Consider socioeconomic status as an additional factor that contributes to CVD risk. [2008] 1.1.15 does not use risk assessment tools for people with pre-existing CVD. [2008, amended 2014] 1.1.16 Do not use a risk assessment tool for people who are at high risk of developing CVD because of familial (See NICE guidelines on familial hypercholesterolemics) or other inherited fat metabolism disorders. [2008, amended 2014] 1.1.17 When using the risk score to inform drug treatment decisions, particularly if it is near to the threshold for treatment, take in account other factors that: may predispose the person to premature CVD and may not be included in calculated risk scores. [2008, amended 2014] 1.1.18 Recognise that standard CVD risk scores will underestimate risk in people who have additional risk because of underlying medical conditions or treatments. These groups include people who are treated for people with HIV with serious mental health problems, people taking medications that can cause dyslipidosis such as anti-psychotic drugs, corticosteroids or immunosuppressive drugs for people with autoimmune disorders such as systemic lupus erythematosus, and other systemic inflammatory disorders. [2008, amended 2014] 1.1.19 Recognise that CVD risk will be underestimated in people who are already taking antihypertensive or lipid modification therapy, or who have recently stopped smoking. Use clinical judgment to decide on further treatment of risk factors in people who are below the CVD risk threshold for treatment. [2008, amended 2014] 1.1.21 Consider people aged 85 or older to be at increased risk of CVD because of age alone, particularly people who smoke or have raised blood pressure. [2008, amended 2014] 1.1.23 Use everyday, jargon-free language to communicate information on risk. If technical terms are used, explain them clearly. [2008] 1.1.24 Set aside enough time during consultation to provide information about risk assessment and allow for any questions to be answered. Further advice may be needed. [2008] 1.1.25 The discussion document relates to advice on risk assessment and individual decision. [2008] 1.1.26 Providing information to the public about their absolute risk of CVD and about the absolute benefits and harms of intervention over a 10-year period. This information should be in the form of: it presents individual risk and profit scenarios and presents the absolute risk of events numerically and uses appropriate charts and text. [2008] 1.1.27 To encourage a person to participate in reducing their CVD risk: Find out what, if anything, the person has already been told about their CVD risk and how they feel about it discovering a person's beliefs about what determines future health (this may affect their attitude to risk change) assessing their readiness to make changes in their lifestyle (diet, physical activity, smoking and consumption Alcohol), to conduct research and long-term use of the drug assess their confidence in making changes in their lifestyle, undergo reviews and take the drug they have discussed from potential future management based on current evidence and the best practice they have involved in developing a joint management plan review with them that they have understood what is discussed. [2008, 2014] 1.1.28 If a person's CVD risk is at the level at which intervention is recommended but refuses to offer treatment, advise them that their CVD risk should be reassessed in the future. Make your choice in your medical notes. [2008, amended 2014] Identification and evaluation of cardiovascular disease (CVD) risk of identifying individuals for a full formal risk assessment for primary CVD prevention in primary care, using a systematic strategy to identify people who are likely to be at high risk of prioritizing individuals based on their CVD risk estimates before the official risk assessment is complete. Estimating your CVD risk using CVD risk factors already recorded in primary care electronic medical records of people older than 40 should complete their estimate of CVD risk checked on a consistent basis of people's preference for formal risk assessment if their estimated 10-year CVD risk is 10% or more discussed in Use the case of the risk assessment process with the person identified as at risk, including the option of reducing any official risk assessment from opportunistic assessment as the main strategy in primary care to identify cvd risk in unsalted full official risk assessment individuals be aware that all CVD risk assessment tools can provide only an approximate value for CVD risk. Interpreting CVD risk scores should always reflect the informed clinical judgment of using the QRISK2 Risk Assessment Tool to assess CVD risk for primary prevention of CVD in people up to and including age 84 does not use a risk assessment tool to assess CVD risk in people with type 1 diabetes. Observing primary prevention for people with type 1 diabetes (below) for consultation on statin treatment for people with type 1 diabetes uses the QRISK2 risk assessment tool to assess the risk of CVD in people with type 2 diabetes does not use a risk assessment tool to assess cvd risk in people with estimated glomerular purification rate (eGFR) of less than 60 ml/min/1.73 m These people are at increased risk of full CVD as many areas of risk assessment tools that may typically record ethnicity, body mass index and early CVD family history in medical records consider socioeconomic status as an additional factor that contributes to the risk of CVD do not use pre-existing CVD risk assessment tools for people at high risk of developing CVD due to familial hypercholesterolemic or other inherited fat metabolism disorders when using the risk score to inform drug treatment decisions, especially if it is close to the treatment threshold, consider other factors that: it may make a person susceptible to premature CVD and may not be included in calculated risk scores that recognize that standard CVD risk scores will underestimate the risk in people who have an additional risk due to underlying medical conditions or treatments. These groups include people who are treated for HIV people with serious mental health People taking medications that can cause dyslipidities such as anti-psychotic drugs, corticosteroids or immunosuppressive drugs will be underestimated by people with autoimmune disorders such as systemic lupus erythematosus, and other systemic inflammatory disorders that detect that CVD risk will be underestimated in people who are currently taking antihymetic or fat modification treatments, or who have recently stopped smoking. Use clinical judgment to decide w to treat more risk factors in people who are below cvd risk threshold for treating severe obesity (body mass index greater than 40 kg/m per perime environment) increases the risk of CVD. Consider this when using risk scores to inform treatment decisions in this group consider people aged 85 or older are at increased risk of CVD due to age alone, especially people who smoke or have raised blood pressure connections about risk assessment and NICE treatment has produced guidance on components of good patient experience in adult NHS services. Among these recommendations are recommendations on risk communication. Follow patient experience recommendations in adult NHS services (NICE CG138) using everyday language without jargon to communicate information about risk. If technical terms are used, they will clearly set aside enough time during the consultation to provide information about risk assessment and allow any questions to be answered. Further consultation may require a discussion document relating to advice on risk assessment and the individual's decision to provide information to the public about their absolute risk of CVD and about the absolute benefits and harms of intervention over a 10-year period. This information should be in the form of: it presents individual risk and profit scenarios and presents the absolute risk of events numerically and uses the appropriate charts and text to encourage the individual to participate in reducing the risk of their CVD: understand what, if anything, the person has already been told about their CVD risk and how they feel about it discovering a person's beliefs about what to determine health. Future (this may affect your attitude to risk change) assess your readiness to make changes in your lifestyle (diet, physical activity, smoking and alcohol consumption), to conduct research and take long-term medication assessing your confidence in making changes in your lifestyle, under review and taking the medication they develop from potential future management based on current evidence and the best practice they have involved in There is a joint management plan review with them that they have understood what is discussed if a person's CVD risk is at the level at which the intervention is recommended but they reject the offer of treatment, advising them that their CVD risk should be reassessed in the future. Record your choice in your heart-protective diet notes advising people at high risk or with CVD to eat a diet where total fat intake is 30% or less total Consumption, saturated fat 7% or less from total energy consumption, dietary cholesterol intake is less than 300 mg per day and where saturated fats may be replaced with monounsaturated and multisaturated fats recommend people at high risk or with CVD: Reduce your saturated fat intake by increasing your monosaturated fat intake with olive oil , Rapeseed oils or extensions based on these oils and their use in food preparation More information and advice on healthy cooking methods can be found in the NHS choosing the recommendations of high-risk people or with CVD to do all the following: Choosing wholegrain types of starchy food reduces their intake of sugar and food products containing refined sugar Including fructose eating at least 5 portions of fruit and vegetables a day eating at least 2 portions of fish per week, including part of oily fish eating at least 4 to 5 portions of indiscriminate nuts, seeds and legumes per week advising pregnant women to limit their oily fish to more than 2 portions per week and to avoid marlin , Shark and swordfish take into account individual circumstances—e.g., drug treatment, companionship and other lifestyle changes when giving dietary advice recommendations and supporting high-risk individuals or with CVD to achieve a healthy diet in line with behavior change: Principles for effective interventions (Nice Public Health Guidance 6) Physical activity recommends people at high risk or with CVD to do the following every week : At least 1 50 minutes of moderate-intensity aerobic exercise or 75 minutes of intense aerobic exercise or a combination of moderate and intense aerobic activity in line with national guidance for the general public recommends that they perform muscle strengthening activities within 2 or more days a week, which is the work of all major muscle groups (legs, buttocks, back, abdomen, chest, shoulders and arms) in line with national guidance for the general population encouraging people who are able to To perform moderate-intensity physical activity due to companionship, medical conditions or personal circumstances to exercise in maximum counseling your safe capacity about physical activity should be taking into account the needs of the individual, preferences and circumstances. Objectives Agree and provide written information about the benefits of activity and local opportunities to be active, in line with four commonly used methods to increase physical activity (NICE Public Health Guidance 2) Combined interventions (diet and physical activity) counseling on diet and physical activity in line with national weight management recommendations providing people at high risk or with CVD who are overweight or obese appropriate advice and support to work in order to achieve And maintaining a healthy weight, in line with obesity (NICE CG43) alcohol consumption, be aware that men should not drink more than 3–4 units a day regularly and that women should not drink more than 2–3 units a day regularly. People should avoid drinking overeating cigarettes Advise all people who smoke to stop, in line with the Smoking Cessation Service (NICE Public Health Guidance 10) to people who want to stop smoking support and advice, and refer to an intensive support service (e.g., stop smoking service service) if a person is unable to accept referrals to an intensive support service, to give them pharmacotherapy in line with smoking cessation and varney services Line for quitting smoking Stanwells and herbal striol does not recommend any of the following to herbal stanols or steriol for the prevention of CVD: People who are treated for primary prevention people who are treated for secondary prevention with people with type 2 diabetes are aware that when deciding on fat correction treatment for CVD prevention , Medications are preferable when there is evidence in clinical trials of beneficial effects on CVD complications and mortality when deciding to prescribe high-intensity statin use statins† and low acquisition of fat measurement costs and referrals measuring both total and high density lipoprotein cholesterol (HDL) to achieve the best CVD risk estimate before beginning fat modification treatment for primary prevention of CVD, make at least 1 fat sample to measure a full fat profile. This should include measurements of total cholesterol, HDL cholesterol, non-HDL cholesterol and triglyceride concentrations. A fasting sample is not required to use clinical findings, lipid profiles and family history to judge the possibility of a family fat disorder instead of using hard fat cutting values alone eliminating possible secondary causes of dyslipidaemia (such as excess alcohol, uncontrolled diabetes, hypothyroidism, liver disease and nephrotic syndrome) before visiting for expert reviews taking into view the possibility of family hypercholesterolemia and reviews as in family hypercholesterolemia (NICE CG7). 1) It is described if they: total cholesterol concentrations greater than 7.7.7 mmol/litre and family history of premature coronary heart disease arrange for specialist evaluation of people with total cholesterol concentrations of more than 9.0 mmol/L or non-HDL cholesterol concentrations of more than 7 5 mmol/L even in the absence of a first-degree family history of premature coronary heart disease refer for an urgent expert review if a person has a triglyceride concentration Of the 20 mmol/L that is not the result of excess alcohol or poor glycamic control in people with triglyceride concentrations between 10 and 20 mmol/L: repeat the triglyceride measurement with a fasting test (after a 5-day interval, but within 2 weeks) and investigate for potential secondary causes of hyperlipidemia and seek expert advice if triglyceride concentrations above 10 mmol/L remain in people with triglyceride concentrations between 4.5 and 9.9 mmol/L: Be aware that CVD risk By underestimated risk assessment tool and optimism management other risk factors CVD now and seek expert advice if non-HDL cholesterol concentrations exceed 7.5 mmol/L statins to prevent CVD deciding whether to start treating statins should be discussed after an informed discussion between the physician and the individual The risks and benefits of statin treatment are made, taking into into consider additional factors such as the potential benefits of lifestyle changes, informed patient preference, accompaniments, polypharmaceian, general failure and life expectancy before starting statin treatment conducting basic blood tests and clinical evaluations, and treating the accompaniments and secondary causes of dyslipidus disorder. Includes all of the following in the assessment: the smoking status of alcohol consumption of body mass index or the measurement of other total cholesterol obesity, Non-HDL cholesterol, HDL cholesterol and Triglycerides HbA1c kidney function and eGFR transaminase levels (alanine aminotransferase or aspartate aminotransferase) are primary thyroid stimulating hormones before providing statin treatment for primary prevention, discussing lifestyle modification benefits and optimism managing all other modifiable CVD risk factors if possible to detect that people may need support for their lifestyle changes. To help them do so, they refer to programs such as exercise referral schemes to give people the opportunity to reassess their risk of CVD after they have tried to change their lifestyle if lifestyle modification is ineffective or inappropriately offer statin treatment after risk assessments providing atorvastatin 20 mg for primary prevention of CVD to people who have a 10% or more 10-year risk of CVD. Estimating the risk level using the QRISK2 assessment tool for people 85 years or older considers atorvastatin 20 mg as statins may benefit in reducing the risk of non-fatal myocardial infarction. Be aware of the factors that may be inappropriate treatment of starting statin treatment in people with CVD with atorvastatin 80 mg ‡ use a lower dose of atorvastatin if any of the following are applied: potential drug interactions do not delay the high risk of adverse effects of patient preference for statin treatment in secondary prevention to manage modifiable risk factors if a person has acute coronary syndrome. Take a fat sample at admission and about 3 months after the start of primary prevention treatment for people with type 1 diabetes consider treating statins for primary prevention of CVD in all adults with type 1 diabetes providing statin treatment for primary prevention of CVD to adults with type 1 diabetes who: Older than 40 years of age or have had diabetes for more than 10 years or have established nephropathy or other RISK FACTORS CVD began treatment for adults with type 1 diabetes with atorvastatin 20 mg primary prevention for people with type 2 diabetes Atorvastatin 20 mg for primary prevention of CVD to people with type 2 diabetes who have a risk of 10% or more CVD aged 10 or over. Estimating the risk level using the QRISK2 assessment tool of people with CKD suggested atorvastatin 20 mg for primary or secondary prevention of CVD to people with CKD:§ Increased dosage if more than 40% reduction in non-HDL cholesterol is not achieved and eGFR is 30ml/min/1.73 m2 or more agreed to use Higher doses started with a kidney specialist if eGFR started less than 30 ml per minute/1.73 m2 follow-up of people in the treatment of statins measuring total cholesterol, HDL cholesterol and non-HDL cholesterol in all people who treated high-intensity statins within 3 months of treatment and aimed to reduce by more than 40% on non-HDL cholesterol. If it doesn't achieve a more than 40 percent reduction in non-HDL cholesterol: discuss adherence and timing of adherence to dose optimism to diet, and consider lifestyle measures to increase the dose if it starts at less than 80 mg atorvastatin and the person is at a higher risk due to companionship, risk score or using clinical judgment to provide annual drug reviews for people taking statins: Use this review to discuss medication adherence and lifestyle modification and address CVD risk factors considering an annual non-fasting blood test for non-HDL cholesterol to inform discussions with people who are stable at the bottom - or moderate-intensity statin benefits likely and potential risks of switching to high-intensity statins when they have a drug review and agree with the person whether change is needed advice and supervision for Adverse effects recommend people who are treated with statins : that other medications, some foods (e.g. grapefruit juice) and some supplements may interfere with statins and always consult with the patient information leaflet, pharmacist or prescriber for advice when starting other medications or thinking about taking the supplement reminds the person to restart statins if they stop taking it because of drug interactions or for treating recurrent diseases before providing statins, Ask the person whether they had persistent general unexplained muscle pain, whether or not associated with previous fat reduction treatments. If they do, measure creatine kinase levels: If creatine kinase levels are more than 5 times the normal upper limit, re-measure Creatine kinase after 7 days. If creatine kinase levels are still 5 times the normal upper limit, statin treatment does not start if creatine kinase levels are raised but less than 5 times the normal upper limit, starting to treat statins at a lower dose recommends people who are treated with statins seek medical advice if they have muscle symptoms (pain, tenderness or weakness). If this happens, measure creatine kinase if people report muscle pain or weakness while taking statins, discover possible causes of other muscle pain or weakness and pose Kinase if they have previously endured statin treatment for more than 3 months creatine kinase levels in people without pumpmatics who are not treated with statins measuring the base enzymes of the liver transaminase (alanine aminotransferase or aspartate aminotransferase) before starting statins. Measurements of liver transaminase within 3 months of starting treatment and within 12 months, but not again unless clinically indicated typically do not prevent people with statin therapy who have liver transaminase levels that are raised but less than 3 times the normal upper limit of statins due to increased blood sugar levels or HbA1c statins in pregnancy : Women's recommendation of the potential for child-raising of potential tratogenic risk of statins and to prevent them taking if pregnancy is possible if pregnancy enables women to plan pregnancy to stop taking statins 3 months before they attempt to conceive and do not restart them until breastfeeding statin intolerance is finished if a person is unable to tolerate the high-intensity statin target for treatment with a maximum tolerance dose to tell the person that any statins Each dose reduces the risk of CVD. If someone reports adverse effects when taking high-intensity statins discuss the following possible strategies with them: stop statins and try again when symptoms have been resolved to check whether symptoms related to statin-related dose reduction in the same group drastically change statins to a lower intensity group seeking expert advice on treatment options for high-risk CVD individuals such as those with CKD , Type 1 diabetes, type 2 diabetes or genetic dyslipidaemias, and those with CVD, which are tolerated to 3 different statins. Counseling can be searched, for example, by phone, virtual clinic or referral to coenzyme Q10 or vitamin D to increase adherence to statin treatment typically do not provide fibres for CVD prevention to any of the following: people who are treated for primary prevention people who are treated for secondary prevention people with CKD people with type 1 diabetes for prevention From nicotinic acid diabetes (niacin) do not offer CVD to any of the following: People who are treated for primary prevention people who are treated for secondary prevention with people with type 2 diabetes, to prevent CVD in people with type 2 diabetes do not provide a bile acid (resin exchange) sequence to prevent CVD to any of the following : People who do not provide primary prevention for secondary prevention people with type 1 diabetes with type 2 diabetes omega-3 fatty acid compounds for cvd prevention to any of the following: People who tell people with type 2 diabetes for primary prevention people who are treated for secondary prevention people with CKD people with type 1 diabetes There is no evidence that omega-3 fatty acid compounds help prevent CVD from combining a sequestrant bile acid (resin exchange anion), fibre, nicotinic acid or omega-3 fatty acid compound with statins for primary or secondary prevention of infected CVD individuals Primary hypercholesterolemic treatment should be considered for ezetimibe treatment in line with Ezetimibe for primary treatment (family and nonfamilial heterozygos) hypercholesterolemic