Statin Therapy Guidelines and Patient Adherence

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Overview

• Part I: Statin Medication Adherence

• Part II: 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk

• Part III: Non-Statin Therapies for LDL-Cholesterol

• Part IV: Statin Intolerance App
Part I: Statin Medication Adherence
Statin Medication Adherence: Issues

• Although the benefits of statin therapy have been evident from a number of randomized clinical trials, their effectiveness can be seen in the real patient population only if there is adequate adherence to the medication regimen.

• Despite well-publicized guidelines and the availability of potentially effective therapies, many patients do not achieve their lipid goals and remain at high risk for cardiac events because of poor adherence.

• The common barriers that could lead to non-adherence can be patient related, physician related or healthcare system related.

• Non-adherence to statin medications is an area of growing concern that can result in increased costs of healthcare, greater hospitalizations, and patient mortality.
Statin Medication Adherence: Previous research

• Statin non-adherence has been associated with around 25% increased hazard for mortality following hospitalization in patients with acute myocardial infarction [1].

• In a study of patients discharged for myocardial infarction, 10% of patients failed to fill their lipid lowering agent one week after discharge [2].

• Physician follow-up and continuity of care combined with increased follow-up and cholesterol testing could promote long term adherence by shortening long gaps in statin use [3].

• One year after dissemination of the 2013 cholesterol guideline, overall treatment rates with statins among patients with ASCVD and diabetes did not change appreciably, and many patients remained either untreated or undertreated [4].
Patient Data on Statin Medication Adherence: Methods

1. Patients enrolled in Medicare Advantage Plan (MAPD) who were non-adherent (PDC ≤ 50%) to statins 17% of patients.

2. Among the non-adherent patients, 51 patients (PDC ≤ 50%) were randomly selected and contacted via phone by pharmacy students trained in motivational interviewing.

3. Identification of potential barriers to statin adherence
Patient Data on Statin Medication Adherence: Results

Frequency distribution of patient demographics

<table>
<thead>
<tr>
<th>Patient Characteristic</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
</tr>
<tr>
<td>&lt;50</td>
<td>5</td>
</tr>
<tr>
<td>50-60</td>
<td>6</td>
</tr>
<tr>
<td>60-70</td>
<td>22</td>
</tr>
<tr>
<td>&gt;70</td>
<td>18</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>27</td>
</tr>
<tr>
<td>Male</td>
<td>24</td>
</tr>
<tr>
<td>Name of prescribed statin</td>
<td></td>
</tr>
<tr>
<td>Atorvastatin</td>
<td>25</td>
</tr>
<tr>
<td>Simvastatin</td>
<td>14</td>
</tr>
<tr>
<td>Rosuvastatin</td>
<td>6</td>
</tr>
<tr>
<td>Pravastatin</td>
<td>5</td>
</tr>
<tr>
<td>Lovastatin</td>
<td>1</td>
</tr>
<tr>
<td>Proportion of days covered (PDC)</td>
<td></td>
</tr>
<tr>
<td>&lt;30%</td>
<td>6</td>
</tr>
<tr>
<td>30-40%</td>
<td>9</td>
</tr>
<tr>
<td>40-50%</td>
<td>36</td>
</tr>
</tbody>
</table>

Barriers to statin medication adherence in elderly non-adherent patients

<table>
<thead>
<tr>
<th>No.</th>
<th>Barriers</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Denial of barrier</td>
<td>27</td>
</tr>
<tr>
<td>2</td>
<td>Forgetfulness</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>Adverse events</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>Cost</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Lack of knowledge</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>Discontinued by provider</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>Pill burden</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Transportation</td>
<td>1</td>
</tr>
</tbody>
</table>
Patient Data on Statin Medication Adherence: Results

Most commonly reported barriers to statin medication adherence

- Forgetfulness
  - Health issues
  - Too busy to remember

- Adverse Events
  - Experienced migraines
  - Sleepiness

- Cost
  - Getting samples
  - Brand-only medication

- Lack of Knowledge
  - Denies the need for medication
  - Patient self-stopped
Part II: 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk$^5$
2013 ACC/AHA Guideline: What’s New?

Focus on ASCVD risk reduction: 4 statin benefit groups
- Goal is to reduce ASCVD events in secondary and primary prevention
- High-intensity and moderate-intensity statin use

A new perspective on LDL-C and/or non-HDL-C treatment goals
- No evidence to support LDL-C and/or non-HDL-C treatment targets
- Appropriate intensity of statin therapy should be used to reduce ASCVD risk in those most likely to benefit

Role of biomarkers and non-invasive tests
- Treatment decisions in selected individuals who are not in the 4 statin benefit groups may be informed by other factors
2013 ACC/AHA Guideline: What’s New?

Global risk assessment for primary prevention

- Recommends use of the new Pooled Cohort Equations to estimate 10-year ASCVD risk in both white and black men and women
- Recommends a discussion between clinicians and patients before initiation of statin therapy
- Indicates, on the basis of RCT data, those high-risk groups that might not benefit
- Focuses statin therapy on those most likely to benefit by more accurately identifying higher-risk individuals

Safety recommendations

- Provides expert guidance on management of statin-associated adverse effects, including muscle symptoms
- Used RCTs to identify important safety considerations of statins and provides expert guidance on management of adverse effects
2013 ACC/AHA Guideline: 4 Statin Benefit Groups

1. Individuals with clinical ASCVD – acute coronary syndromes, or a history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin – without New York Heart Association (NYHA) class II-IV heart failure or receiving hemodialysis.

2. Individuals with primary elevations of low-density lipoprotein cholesterol (LDL-C) ≥190 mg/dL.
2013 ACC/AHA Guideline: 4 Statin Benefit Groups

Individuals 40-75 years of age with diabetes, and LDL-C 70-189 mg/dL without clinical ASCVD.

Individuals without clinical ASCVD or diabetes, who are 40-75 years of age with LDL-C 70-189 mg/dL, and have an estimated 10-year ASCVD risk of 7.5% or higher.
Use of Statin Therapy

1. Acceptable margin of safety when used in properly selected individuals with appropriate monitoring

2. Recommended for primary and secondary prevention of ASCVD

3. Reduced morbidity and mortality associated with ASCVD (based on RCTs)

4. Cost-effective: generic forms available
**2013 ACC/AHA Guideline: Intensity of Statin Therapy**

<table>
<thead>
<tr>
<th>Statin Therapy</th>
<th>High-Intensity</th>
<th>Moderate-Intensity</th>
<th>Low-Intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Daily dose lowers LDL-C, on average, by approximately ≥50%</td>
<td>Daily dose lowers LDL-C, on average, by approximately 30% to &lt;50%</td>
<td>Daily dose lowers LDL-C, on average, by &lt;30%</td>
</tr>
<tr>
<td></td>
<td>Atorvastatin (40†)—80 mg</td>
<td>Atorvastatin 10 (20) mg</td>
<td>Atorvastatin 10 mg</td>
</tr>
<tr>
<td></td>
<td>Rosuvastatin 20 (40) mg</td>
<td>Rosuvastatin (5) 10 mg</td>
<td>Simvastatin 10 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Simvastatin 20–40 mg‡</td>
<td>Pravastatin 10–20 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pravastatin 40 (80) mg</td>
<td>Lovastatin 20 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lovastatin 40 mg</td>
<td>Fluvastatin 20–40 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fluvastatin XL 80 mg</td>
<td>Pitavastatin 1 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fluvastatin 40 mg BID</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pitavastatin 2–4 mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>† down titrate if 80 mg not tolerated (IDEAL study)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>‡ 80 mg may have increased risk of myopathy &amp; rhabdomyolysis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2013 ACC/AHA Guideline: Statin Therapy Recommendations

**Known ASCVD**
- Age ≤ 75 years: High-intensity statin
- Age > 75 years: Moderate-intensity statin

**LDL ≥ 190 mg/dL**
- High-intensity statin
2013 ACC/AHA Guideline: Statin Therapy Recommendations

Diabetes without known ASCVD
- 10-year risk ≥ 7.5%: High-intensity statin
- 10-year risk < 7.5%: Moderate-intensity statin

ASCVD 10 yr. Risk > 7.5%
- Moderate to high-intensity statin
Summary of Statin Initiation Recommendations for the Treatment of Blood Cholesterol to Reduce ASCVD Risk in Adults
Lifestyle Modification as the Foundation for ASCVD Risk-Reduction Efforts

(Both prior to and in concert to cholesterol lowering drug therapies)

- Lifestyle modification critical components:
  - adhering to a heart healthy diet
  - regular exercise habits
  - avoidance of tobacco products
  - maintenance of a healthy weight
2013 ACC/AHA Guideline: Statin Therapy

• RCT evidence shows that ASCVD events are reduced by using the maximum tolerated statin intensity in those groups shown to benefit.

• In secondary prevention, evidence supports high intensity statin therapy to maximally lower LDL-C.

• For primary prevention, use of the new Pooled Cohort Equations to estimate 10-year ASCVD risk.

• Guideline is “patient centered” – Potential for risk reduction benefit, adverse effects, and drug-drug interactions, along with patient preferences, must be considered before statins are prescribed for the primary prevention of ASCVD.
2013 ACC/AHA Guideline: Shared Decision Making

• Shared Decision Making (SDM) when appropriate
• Engage in a clinician–patient discussion before initiating statin therapy, especially for primary prevention in patients with lower ASCVD risk.
• The cholesterol guidelines recommend not only the risk calculation, but also the clinician–patient review of the risk and the decision to take a statin.
• Age is a major contributor to the ASCVD risk calculation.
• Clinical judgment, statin safety issues, and consideration of patient preferences inform the treatment plan.
• Treatment plan is a comprehensive approach to risk reduction that begins with the use of the ASCVD risk calculator and incorporates addressing of the modifiable risk factors.
Initiating Statin Therapy in Individuals With Clinical ASCVD

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**Clinical ASCVD**

- Not currently on statin therapy
- Initial evaluation prior to statin initiation
  - Fasting lipid panel*
  - ALT
  - CK (if indicated)
  - Consider evaluation for other secondary cause (Table 6) or conditions that may influence statin safety (Table 8, Rec 1).

**Table 6.**

Secondary Causes of Hyperlipidemia Most Commonly Encountered in Clinical Practice

<table>
<thead>
<tr>
<th>Secondary Cause</th>
<th>Elevated LDL-C</th>
<th>Elevated Triglycerides</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet</td>
<td>Saturated or trans fats, weight gain, anorexia nervosa</td>
<td>Weight gain, very-low-fat diets, high intake of refined carbohydrates, excessive alcohol intake</td>
</tr>
<tr>
<td>Drugs</td>
<td>Diuretics, cyclosporine, glucocorticoids, amiodarone</td>
<td>Oral estrogens, glucocorticoids, bile acid sequestrants, protease inhibitors, retinoid acid, anabolic steroids, sirolimus, raloxifene, tamoxifen, beta blockers (not carvedilol), thiazides</td>
</tr>
<tr>
<td>Diseases</td>
<td>Biliary obstruction, nephrotic syndrome</td>
<td>Nephrotic syndrome, chronic renal failure, lipodystrophies</td>
</tr>
<tr>
<td>Disorders and altered states of metabolism</td>
<td>Hypothyroidism, obesity, pregnancy*</td>
<td>Diabetes (poorly controlled), hypothyroidism, obesity, pregnancy*</td>
</tr>
</tbody>
</table>

LDL-C indicates low-density lipoprotein cholesterol.

* Cholesterol and triglycerides rise progressively throughout pregnancy (80); treatment with statins, niacin, and ezetimibe are contraindicated during pregnancy and lactation.

Adapted with permission from Stone et al (80).
Initiating Statin Therapy in Individuals Without Clinical ASCVD

No Clinical ASCVD
Not currently on cholesterol-lowering drugs
Initial evaluation prior to statin initiation
- Fasting lipid panel
- ALT
- Hemoglobin A1c (if diabetes status unknown)
- CK (if indicated)
- Consider evaluation for other secondary causes (Table 6) or conditions that may influence statin safety (Table 6, Rec 1)

Evaluate and Treat Laboratory Abnormalities
1. Triglycerides ≤500 mg/dL
2. LDL-C ≤190 mg/dL
   - Secondary causes (Table 6)
   - If primary, screen family for FH
   - Unexplained ALT ≥3 times ULN

Assign to statin benefit group
Counsel on healthy-lifestyle habits

Diabetes and age 40-75 y or LDL-C ≥190 mg/dL

No diabetes, age 40-75 y, and LDL-C 70-130 mg/dL

Estimate 10-y ASCVD risk using Pooled Cohort Equations

≥7.5% 10-y ASCVD risk

=5% to <7.5% 10-y ASCVD risk

<5% 10-y ASCVD risk

Clinicians and patients should engage in a discussion of the potential for:
1. ASCVD risk-reduction benefits
2. Adverse effects
3. Drug-drug interactions
4. Patient preferences

Initiate statin therapy (Figure 2)
Re-emphasize healthy-lifestyle habits

Monitor statin therapy (Figure 5)
Statin Therapy: Monitoring Therapeutic Response and Adherence

- **Indicators of anticipated therapeutic response and adherence to selected statin therapy:**
  - High-intensity statin therapy reduces LDL-C approx. ≥50% from the untreated baseline.
  - Moderate-intensity statin therapy reduces LDL-C approx. 30% to <50% from the untreated baseline.

**Flowchart:**
- **Assess medication and lifestyle adherence**
  - Fasting lipid panel
- **Anticipated therapeutic response?**
  - Yes
    - Reinforce continued adherence
      - Follow-up 3-12 mo
  - No
    - Less-than-anticipated therapeutic response
- **Intolerance to recommended dose of statin therapy?**
  - Yes
    - Management of statin intolerance
      (Table 8, Rec 8)
  - No
    - Reinforce medication adherence
      - Reinforce adherence to intensive lifestyle changes
      - Exclude secondary causes of hypercholesterolemia
      (Table 6)
        - Follow-up 4-12 wk
    - Reinforce improved adherence
      - Increase statin intensity
      OR
      - Consider addition of nonstatin drug therapy
        - Follow-up 4-12 wk & thereafter as indicated

**Notes:**
- * indicates fasting lipid panel
- † indicates dose adjustment
- ‡ indicates consideration of additional therapies
2013 ACC/AHA Guideline: Monitoring Statin Therapy

• A baseline lipid panel should be obtained followed by a second lipid panel 4 to 12 weeks after initiation of statin therapy to determine patient’s adherence.

• Thereafter, assessments should be every 3 to 12 months as clinically indicated.

• LDL-C levels and per cent reduction are to be used only to assess response to therapy and adherence.
2013 ACC/AHA Guideline: Statin Safety Recommendations

- Use moderate-intensity statin therapy in patients who are predisposed to statin-associated adverse effects.
  - Multiple or serious comorbidities, including impaired renal or hepatic function
  - History of previous statin intolerance or muscle disorders
  - Unexplained ALT elevations > 3 times ULN
  - Concomitant use of drugs affecting statin metabolism
  - > 75 years of age
  - History of hemorrhagic stroke
  - Asian ancestry
  - CK should not be routinely measured, although it is reasonable to measure baseline CK in persons at increased risk for adverse muscle events
2013 ACC/AHA Guideline: Statin Safety Recommendations

• Individuals on statin therapy should be evaluated for new onset DM. Those who develop DM should be counselled on a heart-healthy diet, physical activity, healthy body weight, stopping tobacco use. Statin therapy should be continued to reduce their risk of ASCVD events.

• Use caution in individuals > 75 years of age, persons taking concomitant meds that alter drug metabolism, taking multiple drugs, taking drugs for conditions that required complex medication regimens (transplant patients or patients with HIV). Review prescribing information before initiating any cholesterol-lowering drug.
2013 ACC/AHA Guideline: Insufficient Response to Statin Therapy

• In persons with a less-than-anticipated response to statin therapy or are intolerant to the recommended intensity of statin therapy:
  ▪ Reinforce adherence to medication and lifestyle changes
  ▪ Exclude secondary causes of hyperlipidemia
  ▪ Investigate statin intolerance

• In persons at high ASCVD risk receiving the maximum tolerated statin who have a less-than-anticipated therapeutic response, addition of a nonstatin LDL lowering agent may be considered if the benefits outweigh the potential for adverse effects
  ▪ Individuals with clinical ASCVD < 75 years of age
  ▪ Individuals with baseline LDL-C ≥ 190 mg/dL
  ▪ Individuals 40 to 75 years of age with diabetes
Part III: Non-Statin Therapies for LDL-Cholesterol
Patients with ASCVD on Statin for Secondary Prevention

Patient has >50% reduction LDL-C (may consider LDL-C<100 mg/dL if no comorbidities or LDL<70 mg/dL and/or non-HDL-C<100 mg/dL in patients with diabetes) on maximally tolerated statin.

1. Address statin adherence.
2. Intensify lifestyle (may consider phytosterols).
3. Increase to high-intensity statin if not already taking.
4. Evaluate for statin intolerance if unable to tolerate moderate-intensity statin. Consider referral to lipid specialist if statin intolerant.
5. Control other risk factors.

Patient has >50% reduction LDL-C (may consider LDL-C<100 mg/dL if no comorbidities or LDL<70 mg/dL and/or non-HDL-C<100 mg/dL in patients with diabetes) on maximally tolerated statin.

CLINICIAN-PATIENT DISCUSSION FACTORS TO CONSIDER
1. Potential for additional ASCVD risk reduction from addition of non-statin therapy to lower LDL-C.
2. Potential for adverse events or drug-drug interactions from addition of non-statin therapy.
3. Patient preferences.

Decision for no additional medication

Optional non-statin medications to consider

Consider ezetimibe first

Patient has >50% reduction LDL-C (may consider LDL-C<100 mg/dL if no comorbidities or LDL<70 mg/dL and/or non-HDL-C<100 mg/dL in patients with diabetes) on maximally tolerated statin.

Consider adding or replacing with PCSK9 inhibitor second

Continue to monitor adherence to medication and life style, and LDL-C response to therapy.
Patients ≥21 Years of Age without Clinical ASCVD and with baseline LDL-C ≥190 mg/dL. Not Due To Secondary Causes, on Statin for Primary Prevention
Patients Aged 40-75 years without Clinical ASCVD and with Diabetes and Baseline LDL-C 70-189 mg/dL, on Statin for Primary Prevention
Part IV: Statin Intolerance App
ACC Statin Intolerance App

• Guides clinicians through the process of managing and treating patients who report muscle symptoms while on statin therapy.
• Clinicians can use the app to:
  ➢ Answer questions to evaluate possible intolerance to a patient's current statin prescription.
  ➢ Follow steps to manage and treat a patient who reports muscle symptoms on a statin.
  ➢ Compare statin characteristics and drug interactions to inform management of LDL-related risk.
  ➢ App does not discuss intermittent statin therapy with gradual increases to optimize tolerance.
ACC Statin Intolerance App

• The information and recommendations in this app are derived from the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, and the prescribing information for each statin.

• It was developed as part of the American College of Cardiology "LDL: Address the Risk" Initiative and further refined and vetted by physicians, physician assistants, nurse practitioners, pharmacists and other relevant specialties; and through user testing in care settings with patients.

• The Statin Intolerance App is also part of a larger and ongoing effort of the American College of Cardiology to help its members and other clinicians translate guidelines and other clinical policy statements into practice at the point of care.
ACC Statin Intolerance App: How to Download

• This app is available for free in the iTunes and Google Play app stores. You do not have to be an ACC member to download the app.

• Search "ACC Statin Intolerance" on the web or in your app store to download.

• Can use one of the links below to download the app.

  Download the App from iTunes
  Download the App from Google Play
  Launch the Web Version
ACC Statin Intolerance App: Steps to use

**STEP 1:** Answer questions to evaluate possible intolerance to a patient’s current statin prescription

Select symptom type.
- Any from this group – Possible intolerance
  - Muscle ache, Weakness, Soreness, Stiffness, Cramping, Tenderness, General Fatigue
- Any from this group – Unlikely intolerance
  - Tingling, Twitching, Shooting Pain, Nocturnal Cramps, Joint Pain

Select symptom area.
- Bilateral - Possible intolerance
  - Muscle symptoms are generalized (e.g., neck and shoulder pain, lower extremity pain)
- Unilateral - Unlikely intolerance
  - Muscle symptoms are isolated (e.g., knee or shoulder ache)
ACC Statin Intolerance App: Steps to use

**STEP 2:**
Follow steps to manage and treat a patient who reports muscle symptoms on a statin.
STEP 3:
Compare statin characteristics and drug interactions to inform management of LDL-related risk.
ACC Statin Intolerance App: FAQs

• **Who is the intended audience for the App?**

The App is targeted to clinicians who care for patients with or at risk for atherosclerotic cardiovascular disease. While the app is not intended for patient use, it is freely available online and in the app stores to all users.

• **Will any personal or patient information be collected by the ACC Statin Intolerance App?**

The Statin Intolerance App includes some patient demographic questions such as age, sex, race/ethnicity, and statin prescription. This information can be emailed anonymously from the app during the course of an app session to the user's personal email. The app does not record or store any of this information.

• **Are there any plans to link outputs from the App to EHRs?**

Version 1 of the Statin Intolerance App does not currently have the capability for EHR integration. However, the ACC is actively exploring EHR integration as one way to increase the utility of our Apps in the future.
Management of statin myopathy

Statin-associated adverse muscle events

Discontinue statin therapy and wait for symptoms to resolve and CK to return to baseline

Did patient have clinical rhabdomyolysis? (Myoglobinuria or acute renal failure)

No

Drug Interaction with statin?

Yes

Obvious reversible etiology? (eg, drug interaction, hypothyroidism, acute renal failure, biliary obstruction)

Yes

Obvious reversible etiology? (eg, drug interaction, hypothyroidism, acute renal failure, biliary obstruction)

Yes

Did etiology resolve, can consider resuming statin therapy with close monitoring

No

Patient cannot resume statin therapy

Recurrence?

No

Assess for hypothyroidism and vitamin D deficiency

Yes

Modify medication regimen, potentially switching statin to pravastatin, fluvastatin, rosuvastatin, or pitavastatin, and/or switching non-statin medication(s)

No

Recurrence?

No

Abnormal

Correct abnormality and then resume statin therapy with careful monitoring

Recurrence?

Yes

Taking pravastatin or fluvastatin?

Yes

Switch to pravastatin or fluvastatin with careful monitoring

No

Trail of alternate day or less frequent dosing with careful monitoring

Recurrence?

Yes

Discontinue statin therapy

No

Continue statin therapy

Recurrence?

No

Recurrence?

Yes

Discontinue statin therapy

No

Continue statin therapy

CK: creatine kinase

* Pravastatin and fluvastatin appear to be less likely to cause muscle toxicity than other statins.
Recommendations for PCPs

• Think statin therapy as part of your preventive management process as you do vaccinations, cancer screening, etc.

• Emphasize the lifestyle changes that underlie the recommendations.

• Explore the patient preferences and barriers in preventive therapy.

• Consider these key articles for your review and reference:
Case Study

Patient is a 55 year old African-American male with no history of ASCVD and not being treated for hypertension. He is a non-smoker. His sister suffered a myocardial infarction at age 60. His BP = 135/80, HgbA1C=5.7, total cholesterol=210 with HDL=40.

What would you prescribe for this patient?

Using the pooled cohort calculator, this patient’s 10 year risk is 7.9% with a 46% lifetime risk. He would fall in the category of moderate to high dose statins. Although the Preventive Services Task Force recommendations might be less aggressive. By age 60 if nothing changes his risk would calculate at 9.7%

A frank discussion with the patient about his family history and an initial life style modification approach would be in order with repeat testing. If repeat testing does not effect change, consider institution of statin. If patient reluctant, consider CAC for additional data. Results might also help moderate vs. high dose statin decision.
References


