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BRINGING SYMPOSIUM PROCEEDINGS TO THE MANAGED CARE COMMUNITY

New Advances in Lipid Management

Overview

This supplement presents highlights of a satellite symposium held prior to the 74th Annual Scientific Sessions of the American Heart Association in Anaheim, California on November 10, 2001, and a live webcast held on November 15, 2001.

The satellite symposium, *New Goals in Lipid Management: Evolving Evidence*, focused on the role of lipid lowering in reducing the risk of atherosclerosis, the treatment guidelines announced by the National Cholesterol Education Program in May 2001, and emerging evidence from large clinical trials of the benefits of reducing cholesterol levels. It also provided recent insights into vascular protection by high-density lipoprotein cholesterol, and addressed current approaches to identifying and managing patients with metabolic syndrome, which is also known as Syndrome X or the insulin resistance syndrome.

The webcast, *Fresh Data, New Outlooks: Lipid Control in Insulin-Resistant Patients*, focused on the characteristic dyslipidemia seen in patients with insulin resistance, cholesterol goals in these patients and in those with diabetes, and statin therapy and hard endpoints in high-risk patients. The latter presentation featured a review of the MRC/BHF Heart Protection Study, which examined the effects of therapy with simvastatin and antioxidant vitamins in a cross-section of high-risk patients over a 5½-year period. The results of the study were first presented during the Scientific Sessions on November 13, 2001.

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TARGET AUDIENCE

This program is designed for pharmacy and therapeutics committee members, group practice directors, chief medical staff, home health-care directors, hospital directors, cardiologists, pharmacists, and physicians in primary care.

LEARNING OBJECTIVES

Upon completion of this educational supplement, the participant should be able to:

- Discuss the role of lipid lowering in reducing the risk of atherosclerosis.
- Identify ways the new cholesterol guidelines have impacted cholesterol management.
- Review emerging data from some of the latest clinical trials on statin therapy.
- Describe the protective effects of high-density lipoprotein cholesterol.
- Assess current approaches to identifying and managing patients with metabolic syndrome.
- Discuss results of the MRC/BHF Heart Protection Study.
- Identify cholesterol goals for patients with diabetes and metabolic syndrome.
- Explain dyslipidemia associated with insulin resistance syndrome.

New Cholesterol Guidelines Emphasize Risk Assessment

ANAHEIM—The new guidelines to treat high blood cholesterol in adults released by the National Cholesterol Education Program (NCEP) in May 2001 emphasize risk assessment, focus on multiple risk factors, introduce the concept of coronary heart disease (CHD) risk equivalents, and recommend aggressive short-term primary prevention in high-risk patients, according to Scott M. Grundy, MD, PhD, of the University of Texas Southwestern Medical Center in Dallas.

This is in contrast to the first set of guidelines issued by the Adult

Treatment Panel of the NCEP (ATP I), which focused on long-term primary prevention with diet in patients with elevated cholesterol, and the second set (ATP II), which emphasized secondary prevention with diet and cholesterol-lowering drugs in patients with CHD.

The new guidelines (ATP III) introduced Framingham risk scoring to provide a quantitative estimate of an individual patient's 10-year risk for hard CHD (myocardial infarction and coronary death). If the 10-year risk is greater than 20%, the patient is considered to be at high

risk or, in the absence of established CHD, to be CHD risk equivalent (Table 1). Patients whose 10-year risk is between 10% and 20% are at moderately high risk, and those whose 10-year risk is below 10% are at low risk.

"Patients at high risk, CHD risk equivalents, or moderately high risk for CHD within the next 10 years are considered to be at short-term risk and require aggressive primary preventive therapy," Dr. Grundy pointed out. "However, we also have to take into account those

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New Cholesterol Guidelines Emphasize Risk Assessment **CONTINUED FROM PAGE 1**

patients with low-density lipoprotein cholesterol (LDL-C) levels above 160 mg/dL because they are at long-term or lifetime risk for CHD. They deserve attention in clinical practice, regardless of their estimated 10-year risk.”

The inclusion of CHD risk equivalents, particularly diabetes, greatly

expands both the secondary prevention paradigm introduced in ATP II and the number of patients eligible for aggressive LDL-C-lowering therapy, he emphasized.

For patients at high risk or with CHD risk equivalents whose LDL-C levels are at or above 130 mg/dL, the goal is to lower LDL-C to less

than 100 mg/dL with drug therapy, intensive diet and lifestyle changes (Table 2), and maximal control of other risk factors. For those at moderately high risk, the goal is to lower LDL-C to less than 130 mg/dL by diet and lifestyle changes. Drug therapy can be considered if LDL-C is at or above 130 mg/dL after 3 months of diet and lifestyle therapies.

Another difference between the ATP III and previous guidelines is that it includes the metabolic syndrome in the category of moderately high risk (Table 1) and identifies it as a major target of risk reduction therapy, Dr. Grundy said. For those patients, the primary objective is to lower LDL-C, then correct obesity and other metabolic risk factors such as low levels of high-density lipoprotein, high triglycerides, and high blood pressure.

For the 20% of patients with the metabolic syndrome who have triglyceride levels above 200 mg/dL, the treatment options are monotherapy with a statin or an increased statin dose, or combination therapy with a statin and niacin or a fibrate, he continued.

Table 2
Therapeutic Lifestyle Changes (TLC)

- TLC diet**
- Reduced intake of dietary cholesterol (to less than 200 mg/day)
 - Reduced intake of saturated fat (to less than 7% of total calories)
 - Addition of plant stanols/sterols (2 g/day) if needed
 - Addition of soluble fiber (10 to 25 g/day) if needed

Weight reduction

Increased physical activity

Dr. Grundy also noted that patients whose 10-year risk is below 10% warrant drug therapy if: their LDL-C levels are above 150 mg/dL and they have 2 or more risk factors; their LDL-C levels are between 160 and 189 mg/dL and they have 0 to 1 risk factors; or their LDL-C levels are above 190 mg/dL and they have 0 to 1 risk factors. ■

Table 1

Patients at High and Moderately High Risk
<p>High Risk: Established CHD</p> <ul style="list-style-type: none"> ■ History of myocardial infarction ■ History of stable or unstable angina ■ History of revascularization procedures (bypass graft, angioplasty)
<p>High Risk: CHD Risk Equivalent</p> <ul style="list-style-type: none"> ■ Diabetes ■ Multiple risk factors that confer a 10-year risk for hard CHD > 20% ■ Other forms of atherosclerotic disease (eg, peripheral arterial disease, abdominal aortic aneurysm, symptomatic carotid artery disease)
<p>Moderately High Risk</p> <ul style="list-style-type: none"> ■ Presence of 2 or more major risk factors (elevated LDL-C, smoking, hypertension, family history of premature CHD, age ≥ 45 years in men or ≥ 55 years in women, HDL-C < 40 mg/dL) ■ Presence of multiple metabolic risk factors (metabolic syndrome) such as abdominal obesity, atherogenic dyslipidemia, elevated blood pressure, and insulin resistance ± glucose intolerance
<p><small>CHD = coronary heart disease; LDL-C = low-density lipoprotein cholesterol; HDL-C = high-density lipoprotein cholesterol.</small></p>