Lipid Management after Acute Coronary Syndrome

Consensus Advice for General Practitioners

SAHMRI
South Australian Health & Medical Research Institute

Key Messages

- Acute coronary syndrome (ACS) includes unstable angina and myocardial infarction with or without ST segment elevation whether treated with percutaneous coronary intervention (PCI), coronary artery bypass surgery (CABG) or medication alone
- An integrated approach for secondary prevention of future adverse coronary events in patients who have suffered an ACS is recommended including measures such as lifestyle modification and a care plan
- There is a clear, direct relationship between plasma LDL-C levels and future coronary events. The lower the LDL-C level the lower the risk
- No lower threshold level for LDL-C has been identified below which there is no further benefit and there is no evidence of harm with low levels
- Aim for the lowest achievable LDL-C level with maximum tolerated statin dose as first line and, where appropriate, the addition of ezetimibe
- LDL-C target level of **1.4 mmol/L** is recommended based on current evidence, lowered from the current 1.8 mmol/L
- Long-term adherence to treatment is very important. Patients should be encouraged to continue medication and doctors should be guarded against discontinuing treatment due to perceived adverse effects. Lower dose statin in combination with ezetimibe may be helpful
- The above recommendations apply to general and to special populations (see below for additional information)

Special Populations

Diabetes

Dyslipidaemia (elevated triglycerides and low HDL-C) is common in diabetes. However, LDL-C remains the primary target. Fenofibrate further reduces the risk of future coronary events in those with increased triglycerides and low HDL-C.

Aboriginal and Torres Strait Islander Peoples

Increased incidence of adverse events following ACS is demonstrated in this population. They tend to be younger, more likely to smoke tobacco, suffer from diabetes and chronic kidney disease and experience significant barriers to care. The high level of risk warrants the need for aggressive lipid lowering management. Many have elevated triglyceride levels. Therefore consider fenofibrate in addition to statins.

Renal Failure

Renal patients are at a very high level of risk and benefit from maximum statin +/- ezetimibe. There is good evidence that adding ezetimibe to statin treatment is beneficial. There is no evidence to support dose reduction in renal failure.

Elderly

Age is not a contraindication to aggressive lipid lowering treatment.

Familial Hypercholesterolaemia (FH)

Specialist assessment with screening of family members for possible FH should be considered for patients less than 60 years of age with plasma LDL-C remaining > 3 mmol/L receiving maximum tolerated doses of lipid lowering medications; or LDL-C >5 mmol/L if untreated.

Mental Health Disorders

Patients with mental health disorders are generally at very high cardiovascular risk and these conditions are not a contraindication to aggressive lipid lowering treatment.

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Consensus Meeting 7th August 2015

Attendees

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Acknowledgements

Consensus meeting supported with an unrestricted grant from MSD
Attendees all received honorarium from SAHMRI from the unrestricted grant MSD provided

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