

Dyslipidemia Care Guide

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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Information contained in the Care Guide is not a substitute for a health care professional's clinical judgment. Evaluation and treatment should be tailored to the individual patient and the circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient.

SUMMARY

GOALS

- ✓ Identify and treat patients on the basis of Primary vs Secondary Prevention for atherosclerotic cardiovascular disease (ASCVD)
- ✓ Counsel all patients on healthy lifestyle choices
- ✓ Prescribe high-intensity statin therapy for ALL ASCVD patients
- ✓ Decrease morbidity and mortality related to ASCVD

ALERTS

- Statin related adverse effects & potential drug interactions
- Evaluate patient for familial hypercholesterolemia (FH) if LDL-C \geq 190 mg/dL
- DO NOT start dialysis if the patient is on statin

DIAGNOSTIC CRITERIA/EVALUATION

Diagnosis of dyslipidemia is made by measuring serum levels of total cholesterol, low-density lipoprotein cholesterol (LDL-C), high-density lipoprotein cholesterol (HDL-C), and triglycerides (TG). Causes may be genetic (see Attachment A), lifestyle factors or medical conditions that interfere with blood lipid levels. Evaluation includes:

- ✓ **History:** Assess each patient for personal ASCVD risk factors and family history of ASCVD (see page 5)
 - ✓ Estimate patient's **10-year ASCVD risk** based on sex, age, race, total cholesterol, HDL-C, blood pressure, history of diabetes mellitus (DM), and smoking history using American College of Cardiology's (ACC) new [ASCVD Risk Estimator Plus Equation](#) and determine appropriate statin benefit group (see chart below for details).
- ✓ **Physical exam:** Height, weight, body mass index (BMI), waist circumference, blood pressure, cardiac evaluation, peripheral and carotid pulses, vascular bruits, check for tendon xanthomas and xanthelasmas.
- ✓ **Labs:** Non-fasting lipid panel (LP) is acceptable for initial screening, comprehensive metabolic panel (CMP) including uric acid, thyroid stimulating hormone (TSH), Hemoglobin A1c (HbA1c) if DM status is unknown (see page 6 for additional labs).
- ✓ **Patient education:** Explain relationship of dyslipidemia to ASCVD and importance of addressing ASCVD risk factors. Use patient education pages PE1-PE3 for guidance.

TREATMENT

- **Therapeutic Lifestyle Changes:** Recommend 3 month trial of lifestyle changes such as low fat diet, increased exercise, weight loss, adequate sleep, smoking cessation, and control of hypertension (HTN) and/or DM for groups 2, 3, 4 (see below)
- Treatment is managed according to patient's ASCVD risk per table (see Attachment C for Hypertriglyceridemia details)

4 DEFINED STATIN BENEFIT GROUPS AND TREATMENT RECOMMENDATIONS

Secondary ASCVD prevention (Age 18+)	Group 1	Very High Risk ASCVD (See algorithm page 3)	Maximum tolerated statin is recommended: <ul style="list-style-type: none"> • If LDL-C \geq 70 mg/dL: Consider adding ezetimibe If LDL-C remains \geq 70 mg/dL (or non-HDL-C \geq 100): Consider PCSK-9
		Very High Risk ASCVD (See algorithm page 3)	High-or moderate-intensity statin is recommended: <ul style="list-style-type: none"> • If High-Intensity statin: Aim for LDL-C lowering by at least 50% • If Moderate statin: Aim for LDL-C lowering 30-50%
Primary Prevention <i>Assess ASCVD risk in each age group— emphasize adherence to a heart healthy lifestyle</i>	2	Severe Hypercholesterolemia	LDL-C \geq 190 mg/dL – No risk assessment needed → High-Intensity statin. If LDL-C 50% reduction not achieved and fasting TG's \geq 300 mg/dL, after maximal statin and ezetimibe, bile acid sequestrant may be considered.
	3	Diabetes Mellitus in Adults	DM and age 40-75 years → Moderate-intensity statin or do risk assessment to consider high-intensity statin
	4	Primary Prevention over the Life Span (Non-Diabetic) (See algorithm page 2)	Age 18-39 years Estimate lifetime risk to encourage lifestyle to reduce ASCVD risk. Consider statin if family history, premature ASCVD and LDL-C of \geq 160 mg/dL Age 40-75 years with LDL-C of \geq 70- $<$ 190 mg/dL and a 10-year ASCVD risk: <ul style="list-style-type: none"> • $<$ 5% “Low Risk”: Risk discussion. Emphasize healthy lifestyle changes. • 5 to $<$ 7.5%: If Risk enhancers discuss moderate-intensity statin. • 7.5% - $<$ 20% “Intermediate Risk”: Discussion if risk estimate + risk enhancer favor moderate-intensity statin to reduce LDL-C by 30%-49%. • \geq 20% “High Risk”: Initiate statin to reduce LDL-C \geq 50% Age $>$ 75 years Clinical Assessment – Risk discussion

MONITORING

IF ON STATIN: Once lipid-lowering drug therapy has started check patient's **fasting** lipids:

- 1-3 months after starting treatment
- 1-3 months after dose adjustment until within the therapeutic range (See page 18 for information on monitoring side effects)

Once a patient has reached the appropriate/optimal lipid levels:

- Check **fasting** lipids every 12 months (unless there are adherence problems or other reasons for more frequent testing, such as changes in therapy)

IF NOT ON STATIN: After age 20 years, it is reasonable to assess traditional ASCVD risk factors every 4 to 6 years