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En la revista *Canadian Family Physician* se ha publicado una actualización de la guía de práctica clínica sobre la prevención y tratamiento de las enfermedades cardiovasculares en atención primaria.

La guía incluye 24 recomendaciones, que se agrupan en cuatro grupos: 1) diagnóstico y pruebas; 2) intervenciones; 3) intolerancia a las estatinas; 4) seguimiento. A continuación, se muestran las recomendaciones relacionadas con las intervenciones:

- Intervenciones no farmacológicas:
  - _____
  - Se recomienda la dieta mediterránea para la reducción del riesgo cardiovascular.

- Intervenciones farmacológicas:
  - En prevención primaria, en pacientes con riesgo de enfermedad cardiovascular a 10 años ≥20%, se recomienda que los facultativos consensúen con los pacientes el inicio del tratamiento con estatinas (preferiblemente estatinas de alta intensidad).
  - En prevención primaria, en pacientes con un riesgo de enfermedad cardiovascular a 10 años entre el 10% y el 19%, se sugiere que los facultativos consensuen con los pacientes el inicio del tratamiento estatinas (preferiblemente estatinas de intensidad moderada).
  - En prevención primaria, en pacientes con un riesgo de enfermedad cardiovascular a 10 años <10%, se sugiere volver a analizar los niveles de lípidos, inicialmente a los 5 años, y preferiblemente en los 10 años, con estimación del riesgo.
  - En prevención primaria, se desaconseja el uso de hipolipemiantes diferentes a las estatinas en monoterapia o en combinación con estatinas.
  - En prevención secundaria, se recomienda que los facultativos comenten con los pacientes los riesgos y beneficios, y estimulen el inicio de un tratamiento con estatinas de alta intensidad.
  - En prevención secundaria, si se desea una reducción adicional del riesgo cardiovascular más allá del tratamiento maximizado con estatinas, se recomienda comentar el tratamiento con ezetimiba o iPCSK9 (evolocumab y alirocumab). Teniendo en cuenta los posibles efectos

adversos (fibrilación auricular, hemorragia) del tratamiento con icosapento de etilo, se sugiere agregarlo a las estatinas sólo después de considerar ezetimiba o los iPCSK9.

A continuación, se incluye el algoritmo de tratamiento, que excluye el tratamiento de la hipercolesterolemia familiar.

PEER Simplified Lipid Guideline 2023: Summary

Simplified approach Shared decision making Reduce unnecessary testing

Treatment Algorithm

(Excludes familial hypercholesterolemia)

Primary Prevention (no previous CVD)

Men 40-75 years
Women 50-75 years
or
Compelling risk factor (examples: family history, diabetes, smoking)

Secondary Prevention (previous CVD)

Calculate patient's 10-year cardiovascular risk*

Risk <10%	Risk 10-19%	Risk ≥20%
Encourage healthy lifestyle.† Suggest re-estimate cardiovascular risk in 5-10 years.	Encourage healthy lifestyle.† Suggest discussing statins (preferably moderate intensity).	Encourage healthy lifestyle.† Recommend discussing statins (preferably high intensity).

Statin initiated?

No

- Suggest re-estimating cardiovascular risk in 5-10 years, sooner if risk factors change.

Yes

- No repeat lipid testing.
- No baseline creatine kinase or alanine transaminase unless clinically indicated.

For secondary prevention, if additional cardiovascular risk reduction is desired beyond maximum statin dose:

- Recommend discussing ezetimibe or PCSK9 inhibitors.
  - Due to adverse events, suggest EPA ethyl ester (icosapent) only after ezetimibe or PCSK9 inhibitor considered.

* Risk levels based on Framingham, the only 10-year calculator validated in Canada.

† Lifestyle includes smoking cessation, physical activity and the Mediterranean diet

CVD = cardiovascular disease
EPA = eicosapentaenoic acid
PCSK9 = proprotein convertase subtilisin-kexin type 9

Statin Intensity

Statin (mg)	Low	Moderate	High
Atorvastatin	5	10-20	40-80
Pravastatin	10-20	40-80	-
Rosuvastatin	2.5	5-10	20-40
Simvastatin	5-10	20-40	-

Benefit of Statin Therapy

Sample Patient, CVD Risk over 10 years	Statin Option	Relative Risk Reduction	Absolute Risk Reduction	New 10 year Risk on Therapy
20%	Moderate Intensity	25%	5%	15%
	High Intensity	35%	7%	13%

PEER Alberta College of Family Physicians Ontario College of Family Physicians

PEER Simplified Lipid Guideline 2023: Summary

Lipid Lowering Agents

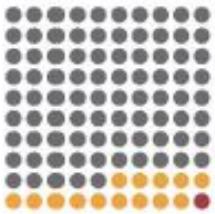
Drug	Prescribing Considerations	CVD Relative Risk Reduction	90-day cost[1]
Statins	• The only lipid lowering agent that decreases all-cause mortality. • Muscle symptoms in first year: 15% versus 14% placebo. • Do not worsen cognition or dementia.	25-35%	$30-50
Ezetimibe	• Mostly studied when added to statins in secondary prevention. • Well tolerated; 10mg daily.	7%	$30-45
PCSK9 inhibitors	• Mostly studied when added to statins in secondary prevention. • Injection site reactions: 3.5% versus 2.1% placebo. • Subcutaneous injections every 2 weeks: alirocumab 75-150mg or evolucumab 140mg.	~15%	$1500-2400
Fibrates	• Increase serum creatinine (2-11% more than placebo), pancreatitis (~0.1% more), altered liver function tests (~5% more); example: fenofibrate.	0-14%*	$60-150
EPA ethyl ester (icosapent)	• Mostly studied when added to statins. • Atrial fibrillation (5.3% versus 3.9% placebo), serious bleeds (2.7% versus 2.1% placebo); 2g twice daily.	~20%	$1000

* 0% if added to statins; up to 14% if not on a statin

[1] *RxFiles PEER/ACFP Pricing Document*

EPA = eicosapentaenoic acid; CVD = cardiovascular disease;
PCSK9 = proprotein convertase subtilisin-kexin type 9

Out of 100 patients on statins, 15 report muscle symptoms, but only 1 is due to statins



Management of Muscle Symptoms Related to Statins

If a patient does not tolerate a statin, discuss statin rechallenge

OPTIONS

- Same statin at same dose
- Lower dose or intensity
- Different statin
- Alternate day dosing

If a patient is unable to tolerate or unwilling to try a re-challenge

Primary prevention

Suggest against non-statin lipid lowering therapy

Secondary prevention

Suggest discussing ezetimibe, fibrate, PCSK9 inhibitor or EPA ethyl ester (icosapent)

FAQ & Helpful Resources

Q: Why do PEER guidelines recommend against targeting low-density lipoprotein (LDL) levels?

A: The vast majority of clinical trials have prescribed fixed statin doses based on CVD risk. Best evidence suggests both strategies (targeting LDL levels or using statins at proven doses) are similarly effective in reducing CVD risk. Targeting cholesterol levels is more complex than use of proven doses. A simplified approach of using proven doses reduces the burden of unnecessary testing for both patients and health professionals. Read more about this issue in the guideline.

Q: Which cardiovascular decision aid should I use?

A: There are many cardiovascular risk calculators. The Framingham model has been validated in Canada. The PEER Cardiovascular Decision Aid (https://decisionaid.ca/cvd/), based on Framingham, has been created for this guideline.

Q: How can I help patients with positive lifestyle changes?

A: Encourage smoking cessation. Providing exercise prescription and information about the Mediterranean diet may be helpful.

RXFILES EXERCISE PRESCRIPTION

MEDITERRANEAN DIET

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