



Diagnosis, Prevention and Management of Coronary Artery Disease

Lipid Management*		
Moderate to high-intensity statin therapy for individuals at increased risk for ASCVD who are likely to benefit from risk reduction are stratified into 4 statin benefit groups.		
Use the ASCVD risk estimator at http://www.acc.org/tools-and-practice-support/mobile-resources/features/2013-prevention-guidelines-ascvd-risk-estimator to determine 10 year and lifetime risks. A patient/physician risk discussion should follow any calculation of risk.		
Statin Benefit Patient Groups ⁽¹⁾	Recommended Statin Treatment	
Clinical ASCVD ⁽²⁾ - secondary prevention	Age ≤75 yrs with no statin-related safety concerns	High-intensity statin
	Age >75 yrs or not a candidate for high-intensity statins	Moderate-intensity statin
Individuals with primary elevations of LDL-C ≥190 mg/dL and without clinical ASCVD - primary prevention	Familial hypercholesterolemia (candidates for statin therapy)	High-intensity statin. (If not a candidate for high-intensity statin, moderate tolerated statin)
Individuals with diabetes, ages 40-75, with LDL-C 70-189 mg/dL and without clinical ASCVD - primary prevention	Estimated 10-yr ASCVD risk <7.5%	Moderate-intensity statin
	Estimated 10-yr ASCVD risk ≥7.5%	High-intensity statin
Individuals with no diabetes, ages 40-75, with LDL-C 70-189 mg/dL and without clinical ASCVD - primary prevention	Estimated 10-yr ASCVD risk ≥7.5%	Moderate to high-intensity statin
	Estimated 10-yr ASCVD risk 5 – < 7.5%	Consider use of moderate-intensity statin. (Moderate evidence available to support. Discuss risks/benefits with patient.)
For patients who do not fall into the above statin-benefit groups, physicians and patients should engage in a discussion regarding the risks and benefits of PCSK9 therapy.		
Consider pill splitting or generic equivalents as available to increase patient compliance.		

Risk Intervention
Lifestyle Modifications
<ul style="list-style-type: none"> Physical activity of at least 150 min/wk of moderate-intensity aerobic activity over at least 5 days/wk or 75 min/wk of vigorous-intensity aerobic activity over at least 3 days/wk and muscle-strengthening activities on 2 or more days/wk that work all major muscle groups. Dietary Intake: Diet plays a role in management.; moderation of sodium intake, a DASH eating plan or a <u>Mediterranean style diet</u> can be beneficial and should be considered with emphasis on eating foods like fish, fruits, vegetables, beans, high-fiber breads and whole grains, nuts, and olive oil while limiting meats, cheeses, and sweets. http://www.heart.org/HEARTORG/HealthyLiving/HealthyEating/Nutrition/Making-Healthy-Choices_UCM_461295_Article.jsp#.Wo8L5W8rKAY Weight Management to achieve and maintain BMI at 18.5 – 24.9 Kg/m, waist circumference at iliac crest level ≤ 40” in men & ≤ 35” in women. Complete smoking cessation. Provide appropriate counseling, pharmacotherapy and referral to formal cessation programs. No exposure to environmental smoke. (See MCMC <u>Community-wide Guideline for Treating Tobacco Use and Dependence</u>).
Blood Lipid Management
Initiate therapeutic lifestyle changes and consider drug therapy.
Diabetes Management
Initiate appropriate therapy to achieve an A1c < 7.0% (Goals should be individualized based on age, comorbid conditions, duration of diabetes, individual patient considerations and other factors.) (See MCMS <u>Community-wide Guideline for Diabetes Care</u>). Every attempt should be made to identify patients at risk for diabetes (insulin resistance, glucose intolerance, obesity, family history, poor diet and exercise habits) to allow early intervention with diet and lifestyle changes to prevent the development of frank diabetes.
ASA Therapy
<ul style="list-style-type: none"> Primary Prevention - The <u>Food and Drug Administration</u> does not recommend aspirin therapy as preventive medicine in people who have not already had a heart attack, stroke or other cardiovascular conditions. See USPSTF Aspirin Therapy for persons aged 50-59 year under Key Recommendations on page 1. As of 2015 the <u>United States Preventive Services Task Force</u> updated its recommendation for Aspirin for the Prevention of Cardiovascular Disease – Primary Prevention. Secondary Prevention - 2 or more risk factors, especially those with CHD 10yr risk of ≥10%, and no contraindications–prescribe 81-162 mg/QD.
Depression Screening
Screen for depression (See MCMS <u>Community-wide Guideline for Major Depressive Disorder</u>)
Disease Management Support
<ul style="list-style-type: none"> One to one interaction for personal education and support. Resource tools to assist with self management of chronic conditions

*Adapted from 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines

1. Characteristics that may predispose patients to statin adverse effects include, but are not limited to: multiple or serious comorbidities, including impaired renal, hepatic function; hx of previous statin intolerance or muscle disorders; unexplained ALT elevations >3 X ULN; age >75 yrs. 2. Atherosclerotic Cardiovascular Disease (ASCVD) defined as acute coronary syndrome, history of myocardial infarction, stable or unstable angina, prior coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be atherosclerotic.

Guidelines are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs.