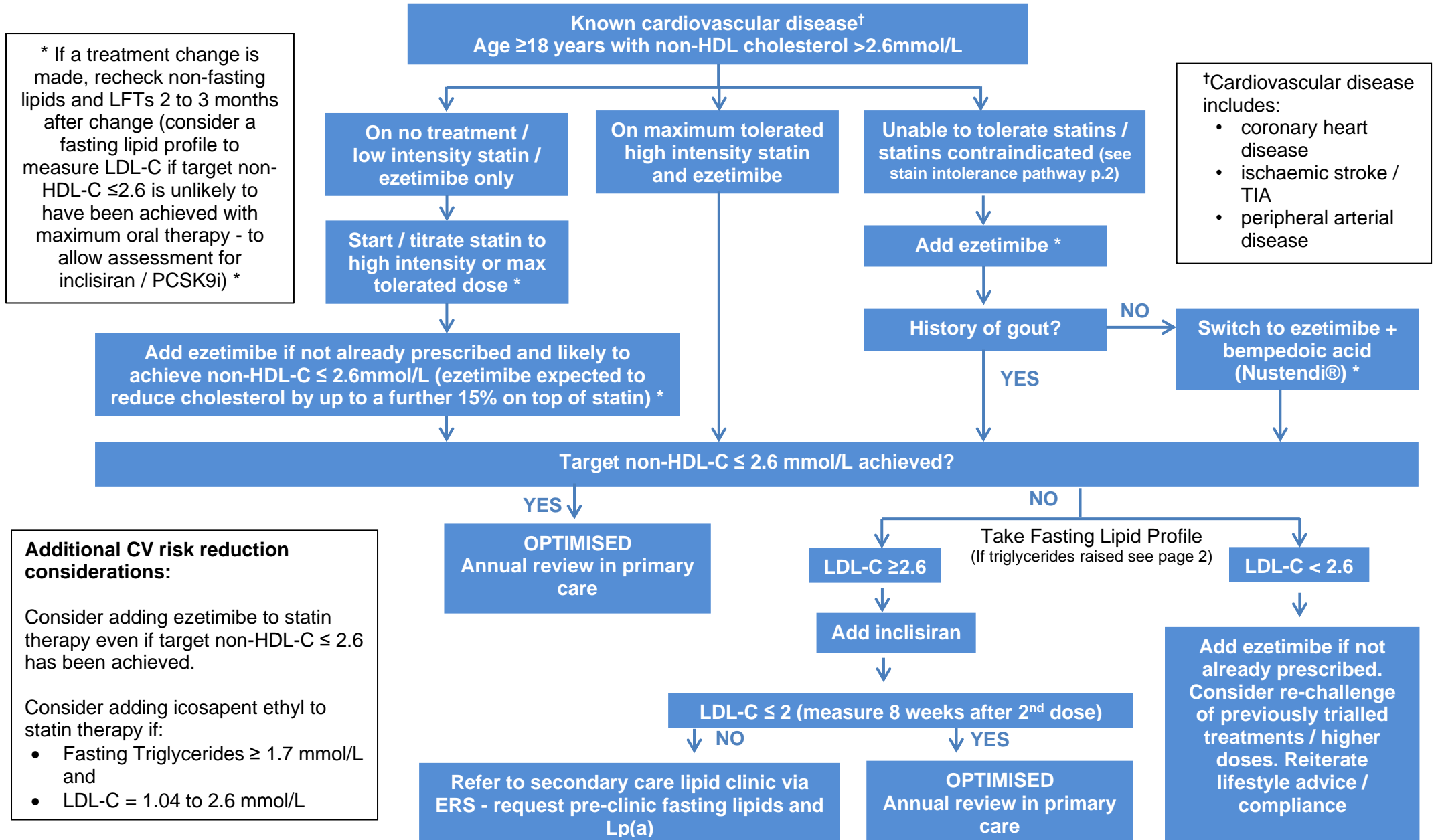


## Gloucestershire Secondary Prevention Lipid Management Pathway



## Statins

High intensity statins (43 to 55% LDL-C reduction):

- Atorvastatin 20mg-80mg
- Rosuvastatin 10mg-40mg

Start with atorvastatin 80mg (or rosuvastatin 20mg if atorvastatin unsuitable) unless there is a reason to start with a lower dose e.g.:

- Interaction with other drugs
- High risk of adverse effects
- The person would prefer to take a lower dose

If unable to tolerate rosuvastatin:

Start rosuvastatin 5mg once weekly titrating up over 3-4 weeks to twice weekly then alternate days then daily.

If side effects develop then reduce to maximum tolerated dose

See also the [Statin intolerance pathway](#)

**Ezetimibe** [NICE TA385](#) (further 10 to 15% LDL-C reduction than statin monotherapy)

If target not met on maximum tolerated statin (or statins not tolerated): Prescribe ezetimibe 10mg od. Consider adding ezetimibe to statin therapy even if target achieved.

**Bempedoic Acid** [NICE TA694](#) (22 to 33% LDL-C reduction with ezetimibe)

Bempedoic acid with ezetimibe is recommended if statins are contraindicated or not tolerated, and ezetimibe alone is insufficient.

Prescribe: Nustendi® (bempedoic acid 180mg + ezetimibe 10mg) 1 tablet od.

Treatment with Nustendi® should be discontinued if hyperuricaemia accompanied with symptoms of gout appear.

**Inclisiran** [NICE TA733](#) (further 48 to 52% LDL-C reduction than maximum tolerated oral therapy)

See [local information sheet](#) for practical guidance.

## Fibrates

If patient already taking a fibrate (fenofibrate / bezafibrate) apply caution in using statin, use lowest dose atorvastatin (risk of myopathy)

**PCSK9 inhibitors** [NICE TA393](#) / [NICE TA394](#)

Secondary Care Prescribing only.

**Icosapent ethyl** [NICE TA805](#)

Prescribe: Two 998mg capsules bd (contraindicated in peanut/soya allergy)

Higher risk of bleeding in patients taking concomitant antithrombotics.

## Before offering or reviewing treatment:

Consider patient preferences, comorbidities, polypharmacy, general frailty and life expectancy.

Also consider principles of shared care decision making [HERE](#).

Ensure that modifiable [risk factors](#) other than cholesterol are also addressed.

## Chronic Kidney Disease:

Atorvastatin: No dose reduction required

Rosuvastatin: If eGFR 30-59 mL/min/1.73m<sup>2</sup>, max dose = 20mg.  
If eGFR <30 mL/min/1.73m<sup>2</sup>, max dose = 5-10mg (*Renal Handbook, off label*).

Ezetimibe: No dose reduction required

Bempedoic acid: Limited experience with if eGFR <30 mL/min/1.73m<sup>2</sup>

Inclisiran: No dose reduction required  
(avoid haemodialysis within 72 hours of inclisiran dose)

Icosapent ethyl: No dose reduction required.

**Drug Interactions:** Patients prescribed warfarin will need regular INR monitoring with statin dose change. Caution when using statins with amiodarone, verapamil, diltiazem, HIV protease inhibitors – use lowest dose atorvastatin.

## Annual Review

- Adherence to medication
- [Lifestyle / Diet](#)
- [CVD risk factors](#)
- Annual lipids check
- Check LFTs if statin started in previous 12 months
- Patient Resources – the Heart UK [website](#) contains a number of useful resources for patients

## Triglycerides

| Triglyceride concentration | Action   |
|----------------------------|--|
| >20 mmol/L                 | Refer to Lipid Clinic for urgent specialist review   |
| 10 – 20 mmol/L             | Take fasting TG (if not already done) after 5 to 14 days. Refer if TG remains >10mmol. Risk of acute pancreatitis. |
| 4.5 – 9.9 mmol/L           | Take fasting TG (if not already done). Optimise CVD risk factors. Refer if TG remains >4.5 and non-HDL-C > 7.5.    |

**CVD Primary Prevention** Guideline [click here](#)

**Familial Hypercholesterolaemia (FH)** Pathway [click here](#)