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Transforming Care, Transforming Communities

Gloucestershire Secondary Prevention Lipid Management Pathway

* If a treatment change is made, recheck non-fasting lipids and LFTs 2 to 3 months after change (consider a fasting lipid profile to measure LDL-C if target non-HDL-C ≤2.6 is unlikely to have been achieved with maximum oral therapy - to allow assessment for inclisiran / PCSK9i) *

Known cardiovascular disease†
Age ≥18 years with non-HDL cholesterol >2.6mmol/L

On no treatment / low intensity statin / ezetimibe only

Start / titrate statin to high intensity or max tolerated dose *

Add ezetimibe if not already prescribed and likely to achieve non-HDL-C ≤ 2.6mmol/L (ezetimibe expected to reduce cholesterol by up to a further 15% on top of statin) *

On maximum tolerated high intensity statin and ezetimibe

Unable to tolerate statins / statins contraindicated (see stain intolerance pathway p.2)

Add ezetimibe *

Switch to ezetimibe + bempedoic acid (Nustendi®) *

†Cardiovascular disease includes:
- coronary heart disease
- ischaemic stroke / TIA
- peripheral arterial disease

Target non-HDL-C ≤ 2.6 mmol/L achieved?

YES

OPTIMISED
Annual review in primary care

NO

Take Fasting Lipid Profile
(If triglycerides raised see page 2)

LDL-C ≥2.6

Add inclisiran

LDL-C ≤ 2 (measure 8 weeks after 2nd dose)

NO

Refer to secondary care lipid clinic via ERS - request pre-clinic fasting lipids and Lp(a)

YES

OPTIMISED
Annual review in primary care

LDL-C < 2.6

Add ezetimibe if not already prescribed. Consider re-challenge of previously trialled treatments / higher doses. Reiterate lifestyle advice / compliance

Additional CV risk reduction considerations:

Consider adding ezetimibe to statin therapy even if target non-HDL-C ≤ 2.6 has been achieved.

Consider adding icosapent ethyl to statin therapy if:
- Fasting Triglycerides ≥ 1.7 mmol/L and
- LDL-C = 1.04 to 2.6 mmol/L

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^2, max dose = 20mg. If eGFR <30 mL/min/1.73m^2, 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^2
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

Approved by: Gloucestershire ICB Drug & Therapeutics Committee
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