South West Yorkshire Partnership NHS Foundation Trust

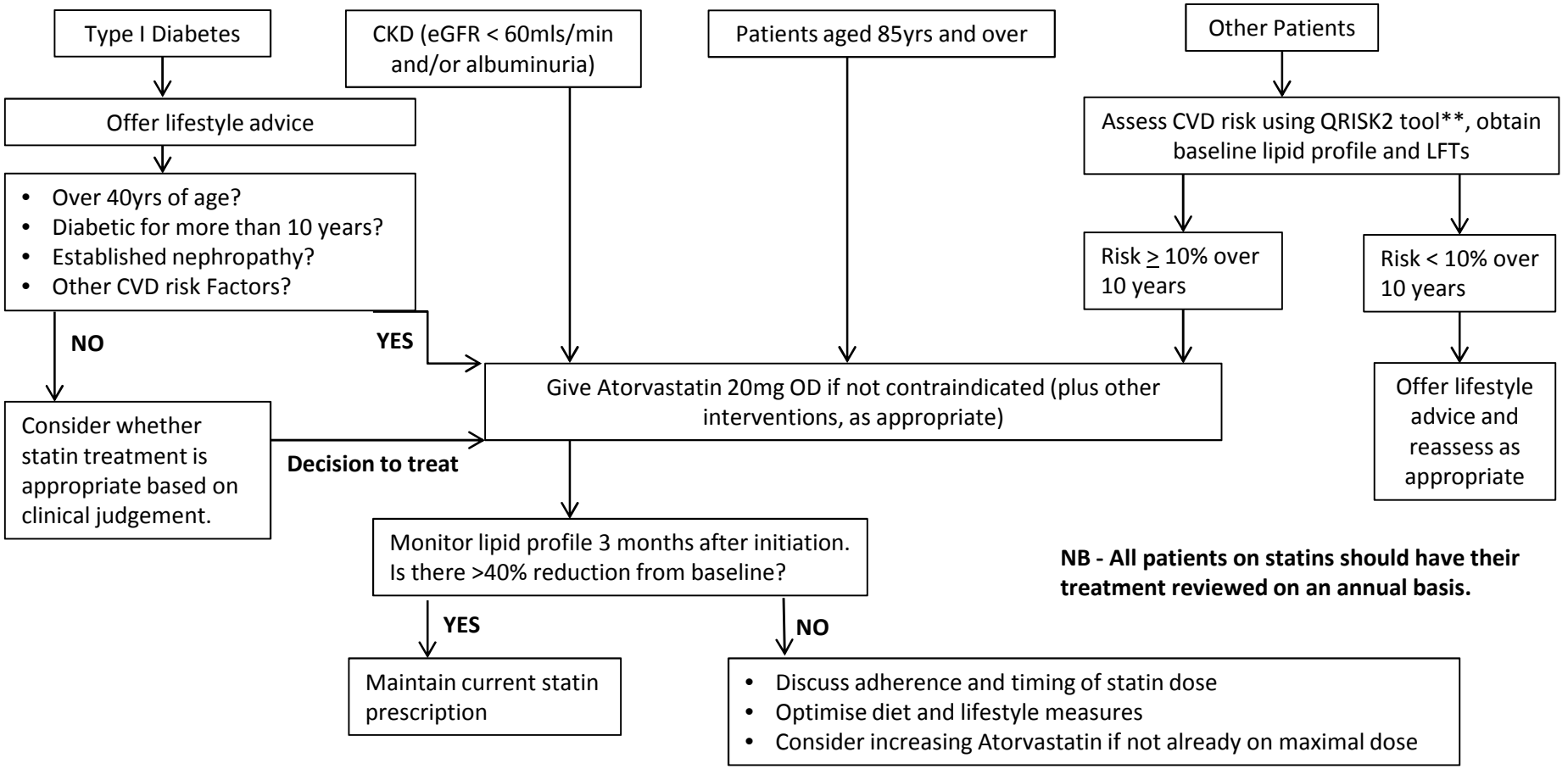
Barnsley Clinical Commissioning Group

Barnsley Hospital NHS Foundation Trust

Barnsley Guideline for the management of Non-Familial Hypercholesterolaemia December 2014

Recommendations taken from NICE Clinical Guideline 181: Lipid Management, 2014

Primary Prevention aim for non-HDLc <2.5mmol/L or LDLc <1.8mmol/L in diabetics, no specific target for non-diabetics in primary prevention (JBS3)



NB - All patients on statins should have their treatment reviewed on an annual basis.

**CVD risk using QRISK2 may be underestimated in the following patient groups:

- Those treated for HIV
- Those with serious mental health problems
- Those taking medicines which may predispose to hyperlipidaemia such as corticosteroids, antipsychotics or immunosuppressants.
- Those already taking lipid modification or antihypertensive therapies.
- Those who have recently stopped smoking
- BMI ≥ 40kg/m^2

Gillian Smith, Lead Pharmacist BHNFT

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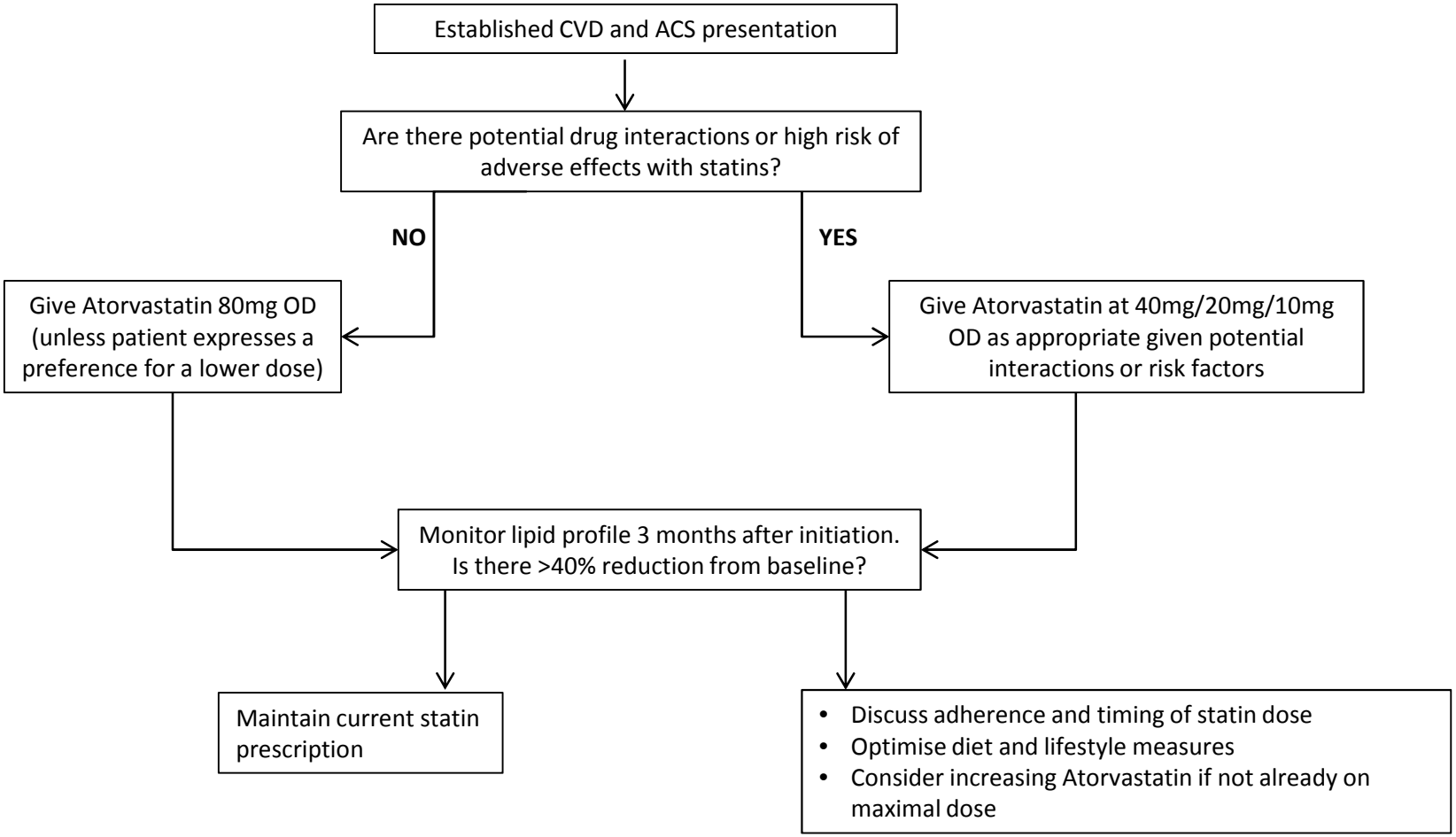
Recommendations taken from NICE Clinical Guideline 181: Lipid Management, 2014

Secondary Prevention aim for non-HDLc <2.5mmol/L or LDLc <1.8mmol/L for all patients in secondary prevention (JBS3)



NB - All patients on statins should have their treatment reviewed on an annual basis.

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Management of Intolerance to Statin Treatment

Where patients are intolerant of their first line statin treatment, the following actions may be considered in further managing hyperlipidaemia and CVD risks. Where changing statin treatments, the agent with the highest (or most patient appropriate) lipid lowering intensity, but with the lowest acquisition cost should be used (see table below).

- Stop the statin and restart once symptoms have resolved to check if the symptoms are statin related
- Reduce the dose of the current statin if appropriate
- Change to an alternative statin within the same intensity group
- Change to an alternative statin within a lower intensity group

Evidence suggests that the long term effects of statins on morbidity and mortality are superior to other lipid lowering agents, and intolerance is not a class effect. Hence where intolerance to a second statin is evident, other statins should be tried before considering alternative agents. The agents with the best tolerability profiles are pravastatin, atorvastatin (if not already tried) and rosuvastatin, but the lipid lowering potential and acquisition cost should also be considered. When initiating atorvastatin or rosuvastatin in previously intolerant patients, start at the lowest available dose and up-titrate as able.

Fibrates:

- Fibrates are the preferred option where intolerance to multiple statins is evident. Bezafibrate MR 400mg and Fenofibrate are the fibrates of choice for use in Barnsley.

Ezetimibe:

- Ezetimibe monotherapy should only be considered for prevention of CVD if multiple statins and fibrate treatment has not been tolerated (or in primary hypercholesterolaemia as per NICE TA 132) since there is minimal outcome data regarding its effectiveness in reducing morbidity or mortality in CVD.
- Ezetimibe may be added to statin treatment if recommended by a specialist, where treatment with statins alone has not produced optimal lipid lowering.

Other lipid lowering agents:

- Nicotinic acid derivatives, bile acid sequestrants and omega-3 fatty acids are not recommended for use in primary or secondary prevention of CVD.

Reduction in low density lipoprotein cholesterol (LDL) (cost for 28 days treatment, ex. VAT, Drug Tariff December 2014) :

Dose (mg/day)	5mg	10mg	20mg	40mg	80mg
Fluvastatin	-	-	21% (£2.41)	27% (£2.48)	33% (£19.20)
Pravastatin	-	20% (£1.43)	24% (£1.65)	29% (£2.00)	-
Simvastatin	-	27% (£0.90)	32% (£0.98)	37% (£1.23)	*42% (£1.81)
Atorvastatin	-	37% (£1.19)	43% (£1.45)	49% (£1.67)	55% (£2.68)
Rosuvastatin	38% (£18.03)	43% (£18.03)	48% (£26.02)	53% (£29.69)	-

- 20-30% low intensity
- 31-40% medium intensity
- Above 40% high intensity

* Advice from the MHRA is that there is an increased risk of myopathy associated with 80mg dose of simvastatin. This dose should only be considered in patients with severe hypercholesterolaemia and high risk of cardiovascular complications who have not achieved their treatment goals on lower doses, and where the benefits are expected to outweigh the risks.