NHS Lincolnshire Community Health Services NHS Trust

NHS Lincolnshire Integrated Care Board

NHS United Lincolnshire Hospitals NHS Trust

Lipid Management Pathway for Secondary Prevention in Cardiovascular Disease

Patient has a diagnosis of cardiovascular disease (Ischemic Stroke, TIA, PAD, ASCVD, MI, Revascularisation)

- Obtain and review full lipid profile, as well as measurement of renal function, thyroid, liver profiles and Hab1c.
- Provide lifestyle advice, use shared-decision making and incorporate patient preference in treatment and care decisions.
- Set LDL-C targets. Aim to achieve for most patients LDL.C <1.8mmol/L or non-HDL-C <2.5mmol/L (or <1.4mmols if the patient is diabetic as classified as very high-risk).

Not on statin or LLT

Offer Atorvastatin 80mg to all patients for secondary prevention.

For post ACS, If LDL ≥3.6mmols/L consider Ezetimibe 10mg in addition to statin therapy as first line treatment.

For renal dosing: Offer Atorvastatin 40mg if eGFR <15mls/min and uptitrate as required to achieve target LDL level**

On statin or other Lipid lowering therapy (LLT)

LDL-C ≥1.8mmol/L or non-HDL-C ≥2.5mmol/L (≥1.4mmol/L if diabetic)

- Ensure maximum tolerated statin dose
- Consider Ezetimibe 10mg
- If LDL-C ≥2.6mmol/L, consider Inclisiran
- If LDL-C >4mmols (or >3.5mmols for recurrent events), consider referral to secondary care for PCSK9i therapy (RED on formulary)

LDL-C <1.8mmol/L or non-HDL-C <2.5mmol/L (<1.4mmol/L if diabetic)

Continue LLT with annual review for adherence, lifestyle advice and relevant

Statin intolerance*

LDL-C ≥1.8mmol/L or non-HDL-C ≥2.5mmol/L (≥1.4mmol/L if diabetic)

- Consider retrying low dose statin
- If true intolerance, consider Ezetimibe 10mg or Ezetimibe 10mg/Bempedoic acid 180mg if Ezetimibe alone has not reduced LDL-C/non-HDL-C sufficiently.
- If LDL-C ≥2.6mmol/L, consider Inclisiran
- If LDL-C >4mmols (or >3.5mmols for recurrent events), consider referral to secondary care for PCSK9i therapy (RED on formulary)

Repeat full lipid profile & liver function tests in 3 months, determine if LDL-C is at target, assess adherence and any adverse events

LDL-C Target achieved

Continue LLT with annual review for adherence, lifestyle advice and relevant bloods.

LDL-C Target not achieved

Reassess adherence, lifestyle advice and consider Intensifying therapy, consider use of Lipid advice and guidance service.

Management of hypertriglyceridemia in secondary prevention

Triglycerides ≥1.7mmols with an LDL-C between 1.04mmol - 2.6mmol **AND** is on statin, consider **Icosapent ethyl**

(Patients who cannot have statins are not covered by Icosapent ethyl's marketing authorisation) ***Do Not Use Fibrates***

Effectiveness of lipid lowering therapies

Drug / Class	Administration	LDL-C reduction
High-intensity statin	Oral tab OD	40-50%
Ezetimibe	Oral tab OD	24%
High-intensity statin + Ezetimibe	Oral tabs OD	55-65%
Inclisiran	Twice yearly injections	52%
PCSK9 inhibitors	Biweekly injections	>60%
Bempedoic Acid	Oral tab OD	28%
Bempedoic Acid + Ezetimibe	Oral tabs OD	40%

Relevant Guidelines/ Notes

National Guidance for Lipid Management Prevention

Statin Intolerance Pathway

Ezetimibe (NICE TA385)

Bempedoic acid / Ezetimibe (NICE TA694)

Inclisiran (NICE TA733)

PCSK9i - Evolocumab (NICE TA394) / Alirocumab (NICE TA393)

Icosapent ethyl (NICE TA805)

*Statin intolerance is defined as unable to tolerate Atorvastatin 20mg or Rosuvastatin 10mg daily dose.

** Local agreement – Marginal increased risk of Rhabdomyolysis if eGFR <15mls/min and to be aware. Check LFT at 3/12 and down titrate statin if LFT >x3.5 URR.

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