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American Heart and American Cardiology Recommendations for Using Statins to reduce Cardiovascular Risk

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Your Life Your Health

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(Note: At an emergency meeting November 17th, the AHA/ACC reviewed evidence that the new calculator of cardiovascular risk is flawed and that implementation of the new guidelines should be delayed. This author believes that the principle behind the guidelines is valid and has been the basis of clinical decision making for the past decade or more. The temporary solution would be to continue to use the current Framingham Risk Scores.)

Newspapers all over America have published articles in the past week. Some report that not as many people need to take cholesterol medicine (statins) as are taking it and others report that the number of people taking statins should double. Two publications from the same authorities have resulted in these reports. They are:

- ***2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk***
- ***2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines***

The conclusion of these reports is that many people who are taking statins may not need them and that many people who are not taking them may need them. The fundamental message is that the current method of deciding who should be on a statin must change. Currently, physicians measure total cholesterol, the good cholesterol (HDL) and the bad cholesterol (LDL) and based on the number make the decision to treat or not to treat with statins.

The new recommendation is that patients no longer be placed on statins on the basis of a “number” but on the basis of their cardiovascular disease risk.

Currently, that risk is determined by a risk measure by the Framingham 10-year risk score for CHF risk assessment by the “Third Report of the National Cholesterol Education Program Expert Panel on Diagnosis, Evaluation and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III).”

The Work Group rejected continuing the use of this risk assessment because all of the research on which it is based was done in a Caucasian (the report used the designation “white” but we reject the use of that designation) population. The Work Group derived risk equations from community-based cohorts that are representative of the Caucasian and African American population.

A new risk equation has been recommended and due to the use of electronic medical records, healthcare providers will be able to utilize this algorithm in treating patients. SETMA expects to have this new tool in use by the time this article is published this week.

This new recommendation does not change the treatment of patients who are known to have cardiovascular disease such as those who have had a heart attack and/or who are known to have high risk of cardiovascular such as patients with diabetes or high blood pressure.

Response to a Friend

A life-long friend of mine wrote for my opinion about the new American Heart and American Cardiology recommendation on the use of statins after reading an article in his local newspaper. I read the AHA/ACA Associations article which is a preliminary copy and I also looked at the calculator which is recommended to determine whether or not a patient should be prescribed a statin.

What we do currently know is:

1. There is empirical evidence that inflamed plaques which are the cause of MIs can be stabilized by statins and anti-inflammatory medications. However, the literature review upon which this report is based suggested that the weight of evidence is against the benefit of statins. This may be true. And, it may be that those of us who have reached or exceeded our “three score and ten,” will live out our lives without a definitive decision being made.
2. I do agree that there are people with very low cardiovascular risk who do not need statins. SETMA calculates the Framingham risk for all of our patients. The following is a link to our explanation of this work: <http://www.jameslhollymd.com/EPM-Tools/pdfs/framingham-tutorial.pdf>. In this we have a “What if Scenario” which basically addresses the issue of “if I make a change, will it make a difference.” This is the fundamental question being addressed by the AHA/ACA, i.e., if we make a change (take a medicine) will it make a difference?
3. In August, 2010, the American Board of Family Medicine recommended that every five years family physician calculate one Framingham Risk Calculator for each of their patients. My colleague and partner, Dr. Alan Leifeste, wrote the ABFM a letter about this. It can be reviewed at this link: <http://www.jameslhollymd.com/print.cfm>
4. SETMA will deploy this new calculator recommended by this study and in the next few years we will have some experience with it (see note above). I think we don’t have an answer right now.
5. As we drive toward sustainable health costs, it will be imperative that we stop using drugs and tests which do not add value to our healthcare delivery. There will be struggles between what we are now doing and what we come to find does not improve health. There will be resistance to change. That resistance is a good thing in that it makes us change slowly. Rapid change in health choices, unless a treatment causes imminent danger, will inevitably result in mistakes.

SETMA's current recommendation is that each patient consults with their physician, nurse practitioner or physician assistant. Those with high cardiovascular risk as judged by the Framingham Risk Scores should probably continue taking their statin for the time being. Those with low cardiovascular risk, who are exercising, not smoking, losing weight and eating a "heart healthy diet," probably don't need statins.

Lifestyle Recommendations of the New Guidelines

Advise adults who are at high cardiovascular risk and who would benefit from LDL-C lowering* to:

- Consume a dietary pattern that emphasizes intake of vegetables, fruits, and whole grains; includes low-fat dairy products, poultry, fish, legumes, nontropical vegetable oils and nuts; and limits intake of sweets, sugar-sweetened beverages and red meats.
- Those at high risk should adapt this dietary pattern to appropriate calorie requirements, personal and cultural food preferences, and nutrition therapy for other medical conditions (including diabetes mellitus).
- They should achieve this pattern by following plans such as the DASH dietary pattern, the USDA Food Pattern, or the AHA Diet. They should aim for a dietary pattern that achieves 5% to 6% of calories from saturated fat. And, they should reduce the percent of calories from trans fat

Advise adults who would benefit from BP lowering to:

- Consume a dietary pattern that emphasizes intake of vegetables, fruits, and whole grains; includes low-fat dairy products, poultry, fish, legumes, non- tropical vegetable oils and nuts; and limits intake of sweets, sugar-sweetened beverages and red meats.
- Adapt this dietary pattern to appropriate calorie requirements, personal and cultural food preferences, and nutrition therapy for other medical conditions (Including diabetes mellitus).
- Achieve this pattern by following plans such as the DASH dietary pattern, the USDA Food Pattern, or the AHA Diet
- Lower Sodium intake -- Consume no more than 2,400 mgm of Sodium a day. / . Further reduction of sodium intake to 1,500 mg/day is desirable since it is associated with even greater reduction in BP; and c. Reduce intake by at least 1,000 mg/day since that will lower BP, even if the desired daily sodium intake is not yet achieved.

Physical Activity Recommendations

- In general, advise adults to engage in aerobic physical activity to reduce LDL-C and non-HDL-C: 3 to 4 sessions a week, lasting on average 40 minutes per

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- In general, advise adults to engage in aerobic physical activity to lower BP: 3 to 4 sessions a week, lasting on average 40 minutes per session, and involving moderate-to-vigorous intensity physical activity