ESC/EAS GUIDELINES ON MANAGEMENT OF DYSLIPIDEMIAS IN CLINICAL PRACTICE

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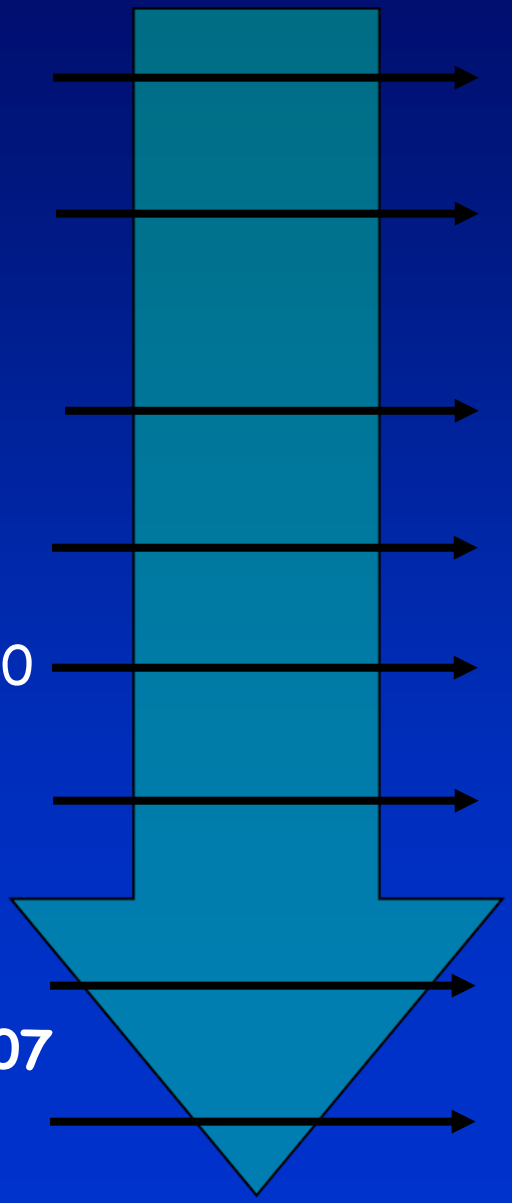
Guidelines - do we need them? Do we read them?

- Over 20,000 biomedical journals, and growing.
- 99% may be irrelevant rubbish hiding 1% with important information which should influence the care of your patients
- GP would need to read 20 journals a day, 365 days a year to keep up to date
- Median reading time for hospital doctors 0-60 min/week (self reported). Up to 75% read nothing in the last week
- Up to date knowledge and clinical performance deteriorate with time

Recent developments in CVD prevention in Europe



1994 — First Joint Task Force Recommendations

1994 — *Joint European Societies Implementation Group on Coronary Prevention*

1995-96 — EUROASPIRE I

1998 — Second Joint Task Force Recommendations

1999-2000 — EUROASPIRE II

2000 — *Joint European Societies CVD Prevention Committee*

2003 — Third Joint Task Force Recommendations

2006-2007 — EUROASPIRE III

2007 — Fourth JointTask Force Recommendations

Lippincott
Williams & Wilkins
a Wolters Kluwer business

EUROPEAN
SOCIETY OF
CARDIOLOGY®

European guidelines on cardiovascular disease prevention in clinical practice: full text

Fourth Joint Task Force of the European Society of Cardiology and other Societies on Cardiovascular Disease Prevention in Clinical Practice

(constituted by representatives of nine societies and by invited experts)

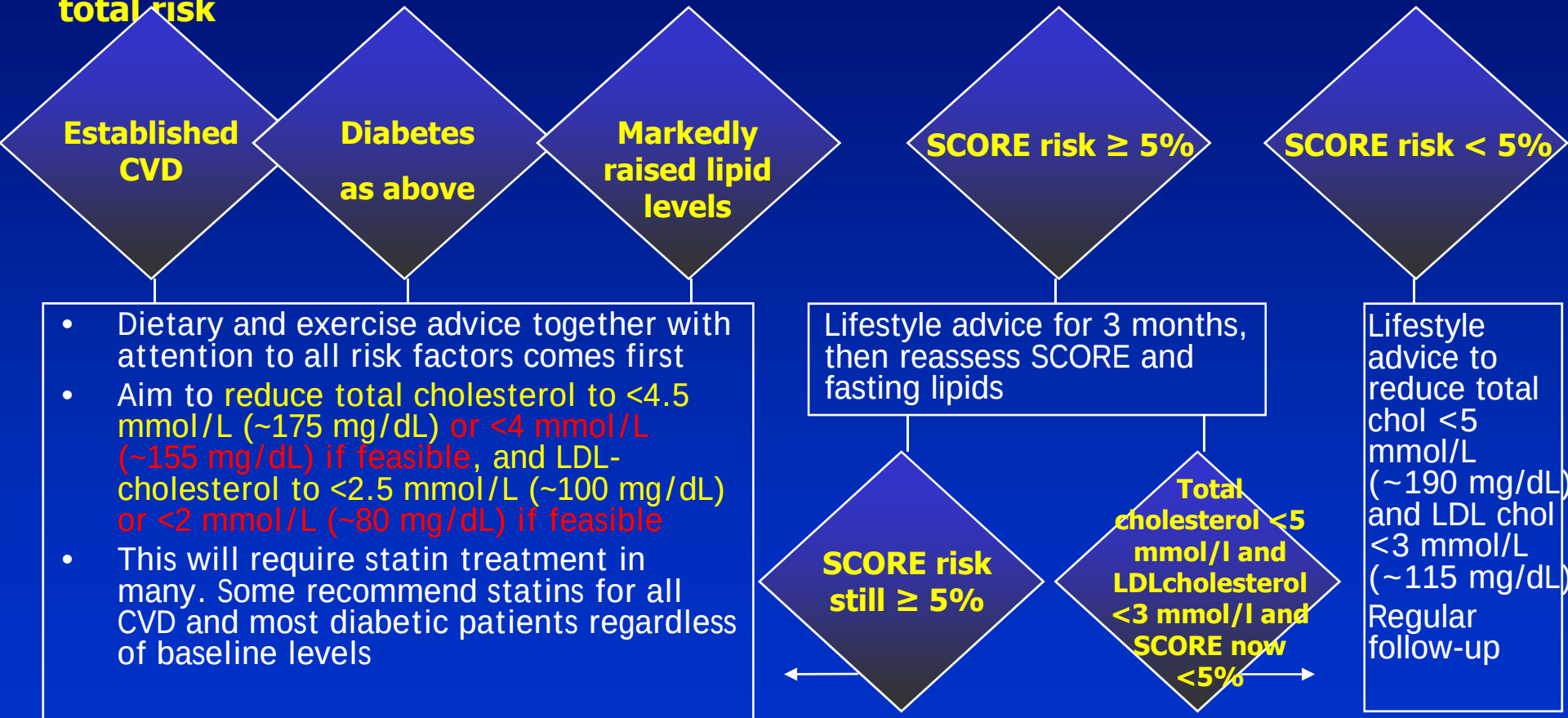
Ian Graham (Chairperson)*[a], Dan Atar[a], Knut Borch-Johnsen[b,c], Gudrun Boysen[d], Gunilla Burell[e], Renata Cifkova[f], Jean Dallongeville[a], Guy De Backer[a], Shah Ebrahim[a], Bjørn Gjelsvik[g], Christoph Herrmann-Lingen[e], Arno Hoes[g], Steve Humphries[a], Mike Knapton[h], Joep Perk[a], Silvia G. Priori[a], Kalevi Pyorala[a], Zeljko Reiner[i], Luis Ruilope[a], Susana Sans-Menendez[a], Wilma Scholte Op Reimer[a], Peter Weissberg[h], David Wood[a], John Yarnell[a], Jose Luis Zamorano[a]

European Journal of Cardiovascular Prevention and Rehabilitation 2007, 14(Suppl 2):S1–S113


PREVENTIVA
KLINIČNI
Klinisk vejledning
Forebyggelse af
- med særligt henblik
dyslipidæmi
LDL
PREVENCIJA
U KLINIČKOJ PRAKSI
PREWENCJA
CHOROBY WIEŃCOWEJ
W PRAKTYCE KLINICZNEJ
PREVENTIE
VAN
IN DE
PREVENCIA
ISCHEMICKEJ CHOROBY
SRDCA
V KLINICKEJ PRAXI
PREVENCE
ISCHEMICKÉ
CHOROBY SRDEČNÍ
V KLINICKÉ PRAXI
ПРЕВЕНЦИЈА
НА
КОРОНАРНАТА АРТЕРИСКА БОЛЕСТ НА СРЦЕТО
ВО
КЛИНИЧКАТА ПРАКСА
ПРОФИЛАКТИКА НА
ИСХЕМИЧНАТА БОЛЕСТ Н
СЪРЦЕТО
В
КЛИНИЧНАТА ПРАКТИКА
PREVENTION
OF
CORONARY HEART DISEASE
IN
CLINICAL PRACTICE
Summary of Recommendations of
the Second Joint Task Force of European
and other Societies on Coronary Prevention
SUOMEN
Lääkärileh
Sepelvaltimotaudin ehkäisy käytännön
lääkärintyössä
zaštitite
srce
Suojaa
sydäntä
protectir
your patient's
heart

Joint European guidelines - Lipids

In ALL cases, look for and manage all risk factors. Those with established CVD, diabetes type 2 or type 1 with microalbuminuria, or with severe hyperlipidaemia are already at high risk. For all other people, the SCORE charts can be used to estimate total risk



Treatment goals are not defined for HDL cholesterol and triglycerides, but HDLcholesterol <1.0 mmol/L (~40 mg/dL) for men and <1.2 mmol/L (~45 mg/dL) for women and fasting triglycerides of >1.7 mmol/L (~150 mg/dL) are markers of increased cardiovascular risk

Primary focus of treatment guidelines is to reduce LDL-Cholesterol

NCEP ATP III Guidelines

- Lower risk:
  LDL-C <4,1 mmol/L
- Moderate risk:
  LDL-C <3,4 mmol/L for individuals with ≥2 risk factors
- High risk:
  LDL-C <2,6 mmol/L for individuals with CHD or CHD equivalents
- Very high risk (optional):
  LDL-C <1,8 mmol/L for high-risk individuals (eg, those with CHD and diabetes)

Joint European Guidelines

- LDL-C <3 mmol/L in general
- <2,5 mmol/L for highest risk individuals with an option of <2 mmol/L (eg, those with diabetes, CHD)
- Triglycerides:
  1.7 mmol/l - marker of increased risk
- HDL-C:
  < 1 in men and < 1.2 mmol/L in women - marker of increased risk

Expert Panel. *JAMA.* 2001;285:2486-2497; Grundy SM et al.*Circulation.* 2004;110:227-239; Eur J Cardiovasc Prev Rehab 2007; 13(Supp 2):E1-E40.

Dyslipidemia guidelines – how should they look like?

- Simple, user-friendly guidelines with improved content and more details concerning lipids than Joint European guidelines
- Increase doctor's (particularly GP's) and patient awareness & education
- Evidence based upon independent research (credible, trustworthy)

Dyslipidemia guidelines – how should they look like?

- In concordance with the Joint European guidelines
- NO DIFFERENT GOALS !
- Fully include the concept of total risk (SCORE + ?)

Dyslipidemia guidelines - for whom do we write them?

- Primarily for GPs (but also for internists, cardiologists etc.)
- Information overload/ reading time mismatch
- GPs overwhelmed with different guidelines (PubMed guidelines-lipids 3612, guidelines-CVD 9260, guidelines 161 166 !)

ESC classes of recommendations

Class I: Evidence/general agreement that treatment is beneficial, useful and effective

Class II: Conflicting evidence-

- **IIa:** Weight of evidence in favour
- **IIb:** Usefulness/efficacy less well established

Class III: Not useful/effective or may be harmful

ESC levels of evidence

A: Multiple randomised clinical trials or meta-analyses

B: Single randomised clinical trial or large large, non-randomised studies

C: Consensus of experts and/or small studies, retrospective studies, registries

Grading the evidence

- While it, reasonably, gives the highest grading to RCTs, it inevitably favours drug treatments over lifestyle measures
- The process is not transparent - is a numerical class or level evidence based, or just an opinion that has been given a number?
- All contributors have to be aware of the principles of EBM and the need to quote available systematic reviews
- Differing types of evidence are needed when considering, for example, lifestyle measures, causality, screening and diagnostic techniques as opposed to therapeutic interventions

The issue of low HDL-Cholesterol and high triglycerides

- New data?
- The residual risk
- How to increase HDL-cholesterol ?– nothing in the Joint European guidelines
- Are all HDL particles beneficial?

Any hazard with very low LDL – Cholesterol?

- Almost nothing in the Joint European guidelines (particularly the issue of mental disorders and low but also high cholesterol etc.)

Children and lipids

- Nothing in Joint European guidelines (“normal” values, when to start with drugs, goals for treatment?)

Elderly and lipids

- Nothing in Joint European guidelines (“normal” values, goals for treatment, effects of diet, side effects of drugs, interactions of lipid lowering drugs with other drugs,?)

Drug combinations and side effects

- Still many doctors hesitate to prescribe combinations because of side effects – what is the reality?
- Not much about this issue in Joint European guidelines

Nutrition and "natural" substances for treating dyslipidemias

- Nothing in the Joint European guidelines (plant sterols, garlic, red rice, polycosanol, green tea, cocoa, etc.)
- The issue of red vine, alcohol

Kidney diseases, dialysis and lipids

- Not much about this issue in Joint European guidelines

Acute coronary syndrome and lipid-lowering drugs

- Not much about this issue in the Joint European guidelines
- When exactly to start, dosage etc.?

Women and lipids in CVD prevention

- AHA Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women (Circulation 2004; 109: 672-93). Good but nothing on the role of women in prevention
- More in Joint European guidelines for CVD prevention but not to much
- WHY are 65% of medical students female yet <5% of consultants? Competence versus androgens?
- YET, in many medical cultures, the effective delivery of prevention is by women - physicians, nurse specialists, physiotherapists, nutritionists etc
- Women & the home - a major and undervalued resource

Draft Timelines

20 & 21 January 2009 *Kick-off meeting* *Chateau Mont Royal Paris*	Presentation of processes Agreement on table of contents, writing assignments Timelines Instructions (writers, circulation, web site, meetings)
End March 2009	Draft 1 finished by section lead authors and sent to their section co-authors for their comments/approval
End April 2009	Draft 1 due in to Chairs with all co-authors comments integrated
13 May 2009 *Meeting 2 Croatia*	Second meeting with the whole group Whole group goes through entire draft and makes comments
14 June 2009	Draft 2 finished by section lead authors and sent to their section co-authors for their comments/approval
28 June 2009	Draft 2 due in to Chairs with all co-authors comments integrated
Beg July 2009	Chairs send new draft to all Task Force Members
10-11 July 2009 *Chateau Mont Royal Paris*	Third meeting with the whole group Whole group goes through entire draft and makes comments
Barcelona 2009	No meeting
End August 2009	Draft 3 finished by section lead authors and sent to their section co-authors for their comments/approval

20 September 2009	Draft 3 due in to Chairs with all co-authors comments integrated
11 October 2009	Chairs create first Master copy and homogenize/balance all sections
8 November 2009	Internal review of Master copy 1 by all the Task Force Members
30 November/1 December 2009 *Meeting 4?*	Fourth meeting to go through Master copy 1 with all TF members
January 2010	Official CPG review process Comments from the ESC reviewers and CPG
February 2010 *Meeting 5?*	Task Force integrates review comments into the document and give feedback to the reviewers
March 2010	Document submitted to CPG for validation from reviewers
April 2010	Publication approval and submission to EHJ
May-June 2010	Proofreading and formatting of document for publication
Summer 2010	Publication of document in EHJ & Atherosclerosis

Table of Contents

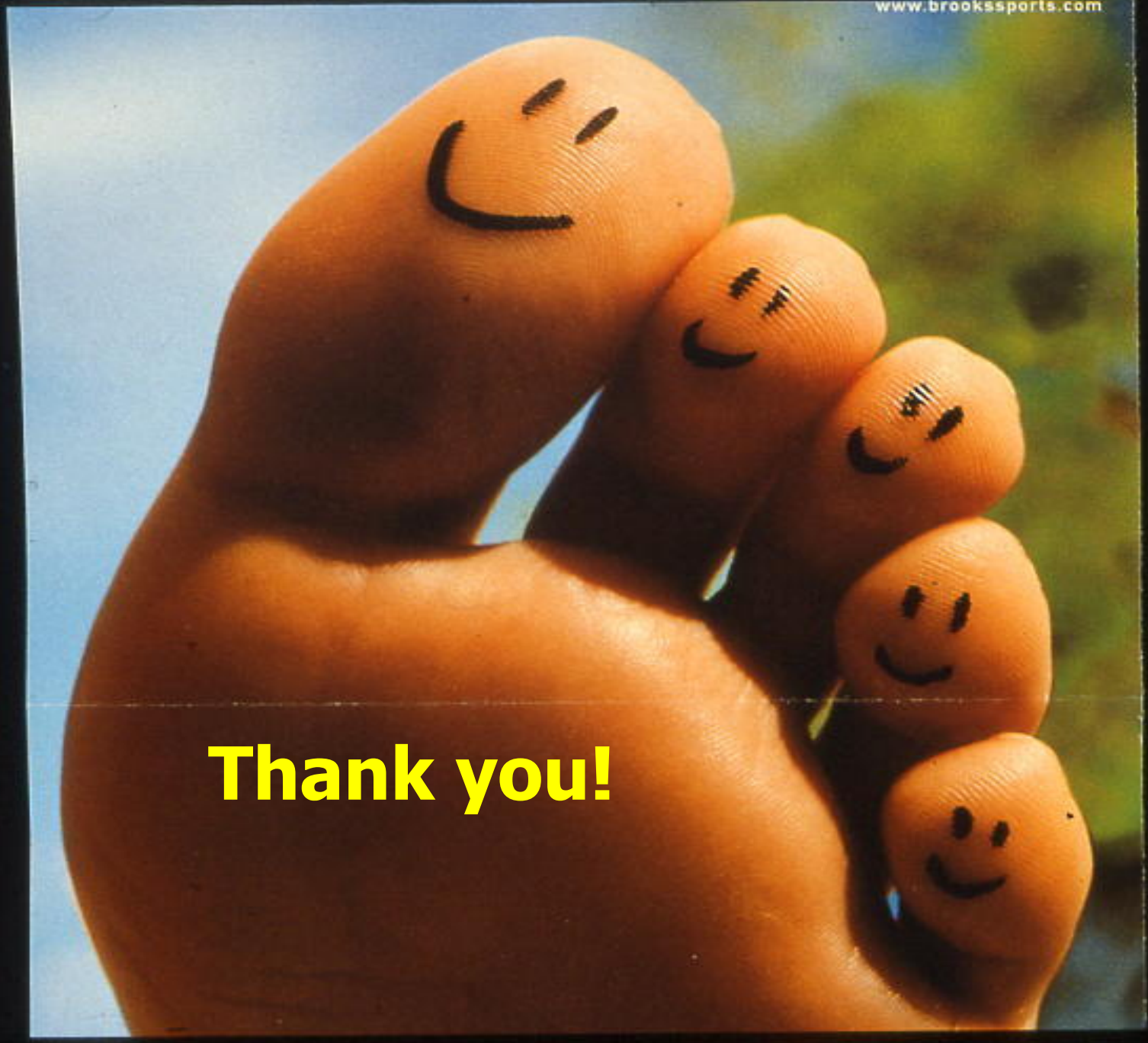
Section	Sub-Section
6. Treatment of dyslipidemias in different clinical settings	Familial forms
	Children
	Women
	Elderly
	Metabolic risk factors (Diabetes (type 1 and 2, glucose intolerance, obesity)
	HF and valve disease
	Renal dysfunction, dialysis
	Transplantation patients
	PAD
	Stroke
	HIV
	Coronary Disease (including ACS)
7. Patient follow-up	
8. How to improve compliance to lifestyle changes and therapy and implementation	
9. Gaps in evidence and emerging data	
10. Conflict of Interest Statements	
11. References	

40 references per journal page, 2 to 4 tables per journal page.
Total number of words, including tables, figures and references, for the whole document: 35000 (35 journal pages maximum)

Guidelines are nothing without implementation

- Guidelines alone are good for the vanity of the authors and bad for rain forests; they are a waste of time without a defined implementation strategy

(Ian Graham)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Thank you!