ESC/EAS Guidelines for the management of dyslipidaemias: Addenda

The Task Force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and the European Atherosclerosis Society (EAS).

Developed with the special contribution of: European Association for Cardiovascular Prevention & Rehabilitation†

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Councils: Cardiology Practice, Primary Cardiovascular Care, Cardiovascular Imaging.
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**Keywords**
- dyslipidaemia
- cholesterol
- triglycerides
- treatment
- cardiovascular diseases
- guidelines

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**Total Cholesterol (mmol/L)**

SCORE chart for use in low risk regions - HDL 0.8 mmol/L
**ESC/EAS Guidelines**

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**SCORE chart for use in low risk regions - HDL 1.0 mmol/L**
### ESC/EAS Guidelines

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**SCORE chart for use in low risk regions - HDL 1.4 mmol/L**
SCORE chart for use in low risk regions - HDL 1.8 mmol/L
**SCORE chart for use in high risk regions - HDL 0.8 mmol/L**

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**Total Cholesterol (mmol/L)**
### ESC/EAS Guidelines

**SCORE chart for use in high risk regions - HDL 1.0 mmol/L**

The chart above illustrates the risk assessment for cardiovascular disease using the SCORE system. The chart categorizes individuals into different risk groups based on age, sex, smoking status, systolic blood pressure, and total cholesterol levels.

- **FEMALES**
- **MALES**

The chart uses a color-coded system where:
- **Red** indicates high risk.
- **Orange** indicates moderate risk.
- **Green** indicates low risk.

For example, a female non-smoker aged 65 with a systolic blood pressure of 140 mmHg and total cholesterol of 6 mmol/L would fall into the low-risk category.

The chart is a valuable tool for healthcare professionals to perform risk assessments and tailor interventions accordingly.
### SCORE chart for use in high risk regions - HDL 1.8 mmol/L

<table>
<thead>
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<th>Non-smokers</th>
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Total Cholesterol (mmol/L)
Addendum II. Practical approach to reach low-density lipoprotein-cholesterol goal

The proposed approach requires the estimation of the distance from the target that can easily be obtained by the use of the following table. Once the distance from a target is determined, then by interpolation the average response to a statin can be determined and the drugs that can help in reaching that target identified from the figure.

Intolerance to a statin, clinical conditions of the patient, and possible interactions with concomitant drugs should also be taken in account.

<table>
<thead>
<tr>
<th>STARTING LDL-C (mmol/L</th>
<th>% REDUCTION TO REACH LDL-C</th>
<th>&lt;1.8 mmol/L (&lt;70 mg/dL)</th>
<th>&lt;2.5 mmol/ (&lt;100 mg/dL)</th>
<th>&lt;3 mmol/L (&lt;115 mg/dL)</th>
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<td>&lt;22</td>
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Table  Percentage reduction of LDL-C requested to achieve goals as a function of the starting value.

Figure  A systematic review and meta-analysis on the therapeutic equivalence of statins.

Addendum III. Inhibitors and inducers of enzymatic pathways involved in statin metabolism

For more information, see US FDA website with information for health professionals (drugs): [www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/default.htm](http://www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/default.htm)

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<th>Inducers</th>
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<td>Ketoconazole, itraconazole, fluconazole, erythromycin, clarithromycin, tricyclic antidepressants, nefazodone, venlaxine, fluvoxamine, fluoxetine, sertraline, cyclosporin A, tacrolimus, mibefradil, amiodarone, danazol, diltiazem, verapamil, protease inhibitors, midazolam, corticosteroids, grapefruit juice, tamoxifen</td>
<td>Phenytoin, phenobarbital, barbiturates, rifampin, dexamethasone, cyclophosphamide, carbamazepine, omeprazole, St John's Wort</td>
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<tr>
<td>CYP2C9 Fluvastatin, rosvuastatin, pitavastatin</td>
<td>Ketoconazole, fluconazole, amiodarone, sulfaphenazole, oxandrolone, dronedarone, warfarin</td>
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<td>OATP1B1 All statins</td>
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Addendum IV. Additional references

References in addition to those listed in the full text document of the ESC/EAS Guidelines on the management of dyslipidaemias.

These additional references are given by section.

1. Preamble

2. Introduction

No additional references

3. Total cardiovascular risk


4. Evaluation of laboratory lipid and apolipoprotein parameters


5. Treatment targets


6. Lifestyle modifications to improve the plasma lipid profile


8. Drugs for treatment of hypertriglyceridaemia


Kamanna VS, Kashyap ML. Nicotinic acid (niacin) receptor agonists: will they be useful therapeutic agents? Am J Cardiol 2007;100(suppl):53N–61N.
9. Drugs affecting high-density lipoprotein


10. Treatment of dyslipidemias in different clinical settings


11. Monitoring of lipids and enzymes in patients on lipid lowering therapy.


12. How to improve adherence to lifestyle changes and compliance with drug therapy.


