Canadian Cardiovascular Society | Perspectives in Clinical Cardiology

The 5 Essentials: Conundrums in Lipids and Atherosclerosis

"When close is not enough!"

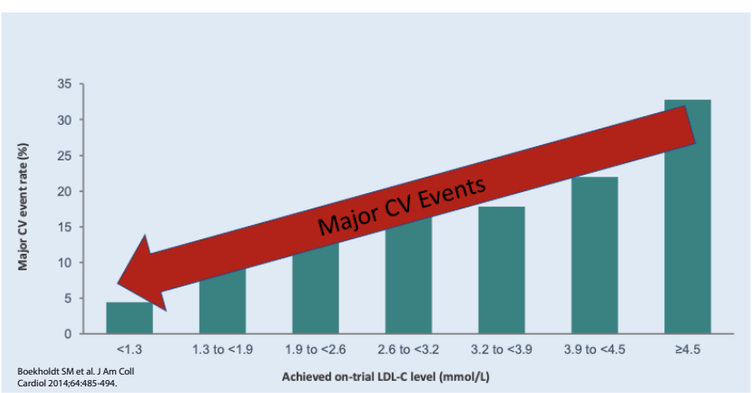
1. Thresholds of lipids requiring action.

CCS advocates for thresholds of lipids requiring action based on LDL-C, non-HDL-C or apoB;

a. Look first at TG.
b. Interpret the lipid profile.
c. Measure Lp(a) once-it is the risk enhancer of lipids.

"We recommend that when TG is > 1.5 mmol/L non-HDL-C or Apo B should be used instead of LDL-C as the preferred lipid parameter for screening" (Strong recommendation, high-quality evidence.)

If TG < 1.5 mmol/L	If TG ≥ 1.5 mmol/L		Clinical Significance
LDL-C mmol/L	Non-HDL-C mmol/L (percentile equivalents)	apoB g/L (percentile equivalents)	
5.0	5.8	1.45	Threshold to treat in I° prevention low risk
3.5	4.2	1.05	Threshold to treat in I° prevention moderate risk
2.0	2.6	0.80	Threshold to intensify in I° prevention
1.8	2.4	0.70	Threshold to intensify in 2° prevention



Boekholdt SM et al. J Am Coll Cardiol 2014;64:485-494.

2. Lower is better, lowest is best, very low LDL-C is safe.

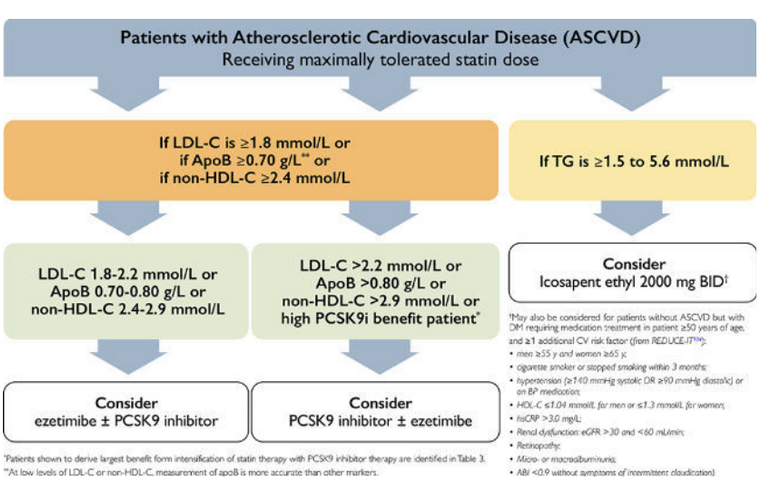
Major CV events: fatal or non-fatal MI, fatal "other" CHD, hospitalization for unstable angina, fatal or non-fatal stroke.

3 & 4. Pharmacotherapy

3. Statins are the fundamental pharmacotherapy.

Confidence is required to address "Goal-inhibiting statin intolerance" efficiently and to overcome nocebo effects.

4. Statin add-on therapies are few: ezetimibe, PCSK9i's, IPE.



5. Stay alert for...

a. Heart Failure
b. Kidney function - measure eGFR, UACR
c. HgbA1C

There are diabetes-associated medications with profound cardiorenal benefits.

To learn more visit **CCS.CA/PCC**

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