High-dose

40 - 80 ma

20 - 40 mg

N/A

N/A

N/A

N/A

VA/Dod CLINICAL PRACTICE GUIDELINES

The Management of Dyslipidemia for

Sidebar 1: CVD and Equivalents VA/DoD Evidence-Based Practice

- MI or ACS Discuss lack of CABG/PCI
 - Stable CAD (angina or equivalent)
 - Atherosclerotic CVA/TIA PAD (claudication or AAA)
 - - Does not include asymptomatic incidental finding of potential atherosclerosis (e.g., CAC)

Sidebar 2: Higher Risk CVD Patients

- MI or ACS in past 12 months: or Recurrent ACS, MI, or CVA; or
- Known CVD (see Sidebar 1) and any of the following: currently smoking, DM, PAD, or CABG/PCI
- There are no evidence-based recommendations for patients under age 40 because there is no evidence for the benefit of lipid screening and treatment within this age group. In patients younger than 40 years old interested in pursuing lipid testing and management, shared decision making is recommended to discuss the risks and unknown benefit of pharmacotherapy, with therapeutic lifestyle changes being the primary focus of CVD primary prevention.
- Suggest regular aerobic activity of any intensity or duration. Although incremental benefit is associated with increased doses of physical activity, lower doses including leisure time activity (i.e., walking, landscaping, washing dishes) are associated with benefit when compared to mostly sedentary behavior. A provider's considerations when recommending physical activity might include a patient's motivation, functional capacity, and physical activity preferences.

Sidebar 3: Drug Doses Generic name Moderate-dose[‡]

10 - 20 mgAtorvastatin

Rosuvastatin 5 - 10 mg

20 - 40 mgSimvastatin

Fluvastatin

Pravastatin 40 - 80 mg40 - 80 mgLovastatin

Pitavastatin $1 - 4 \, \text{mg}$ N/A In patients who are intolerant of statins: after washout

80 mg (XL) or 40 mg BID

(e.g., 1 month), re-challenge with same or a different statin or

- lower dose, and if that fails, a trial of intermittent (nondaily) dosina Intensified patient care (e.g., phone calls, emails, patient education, drug regimen simplification) may improve
- adherence to lipid-lowering medications
- Statin doses listed as "moderate" are equivalent to moderate intensity; statin doses listed as "high" are equivalent to high intensity

Abbreviations: AAA: abdominal aortic aneurysm; ACS: acute coronary syndrome; BID: twice a day; CABG: coronary artery bypass graft; CAC: coronary artery calcium; CAD: coronary artery disease; CVA: cerebral vascular accident; CVD: cardiovascular disease; DM: diabetes mellitus; EF: ejection fraction; ESRD: endstage renal disease; HF: heart failure; LDL: low density lipoprotein cholesterol; mg/dL: milligrams per deciliter; MI: myocardial infraction; PAD: peripheral arterial disease; PCI: percutaneous coronary intervention: TIA: transient ischemic attack: XL: sustained release

evidence demonstrating Does patient have HF benefit and continue Yes with EF <35%, ongoing care ESRD, or life expectancy <5 years? Recommend stepped intensification: Does patient have . Maximize statin or add Yes higher risk CVD? ezetimibe 2. Consider PCSK9 inhibitor (see Sidebar 2) only after maximizing statin Nο and adding ezetimibe Does patient have CVD Yes per Sidebar 1, DM, or If MI, ACS, or LDL ≥190 mg/dL? CABG/PCI in past No 6 weeks, refer for Is patient's 10-year Recommend cardiac rehab CVD risk >12%? moderatedose statin (see Sidebar 3) Recommend Is patient's 10-year dietitian-led risk 6 - 12% and Yes Mediterranean does patient prefer diet for risk >12% statin treatment? Recommend regular aerobic No exercise† and smoking cessation (if applicable) 13 Follow up evaluation: 1. Primary evaluation, no statin: Lipids every 10 years, recommend non-fasting · Repeat risk evaluation at Box 1 Every 2 years if 6 – 12% Every 5 years if <6% · If risk factors change

Cardiovascular Risk Reduction

Patient ≥40 years old*

- 2. Secondary prevention: lipids as needed only if higher risk and willing to intensify
- 3. Once on optimal therapy, no need to recheck lipids routinely

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Patient Education on the Mediterranean Diet	
Eat More	Eat Less
 Fruits and vegetables Whole grains Seafood (primarily fatty fish), skinless poultry Tree nuts, peanuts, nut butters Legumes Olive oil Low-fat milk and cheese Red wine* 	 Red meat Processed meat Full-fat milk and cheese Butter or stick margarine Commercial bakery goods Avoid trans fat

^{*} Providers should consider the risk of recommending alcohol to individual patients.

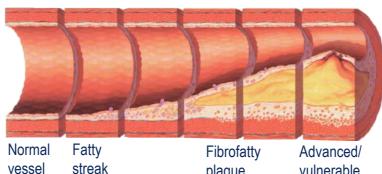
Patient Education on Aerobic Exercise

- Avoid being sedentary.
- Movement is better than no movement. Some exercise is better than no exercise. Even activities not typically thought of as exercise such as walking, doing the dishes, taking the stairs instead of the elevator, or working in the yard are associated with lower risk for cardiovascular disease.
- Start low and go slow. Over days and weeks, try to add a little more movement as tolerated. Increasing activity too rapidly can lead to injuries and burn out.
- Observational data indicates a dose-response relationship between aerobic activity and a reduction in cardiovascular risk.

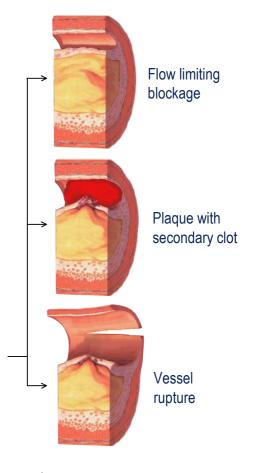
Examples of Cardiovascular Risk Calculators

- The Framingham Risk Score (FRS) is available at: https://www.thecalculator.co/health/Framingham-Risk-Score-Calculator-for-Coronary-Heart-Disease-745.html
- The Pooled Cohort Equation (PCE) is available at: https://clincalc.com/cardiology/ascvd/pooledcohort.aspx
- The VA Cardiac Risk Factor Score (VARS-CVD) is available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5561663/

Atherosclerosis Disease Progression¹







¹ The Atherosclerosis Disease Progression image can be found at:

https://commons.wikimedia.org/wiki/File:Late complications of atherosclerosis.PNG

Access to the full guideline and additional resources are available at the following link: https://www.healthquality.va.gov/guidelines/cd/lipids/