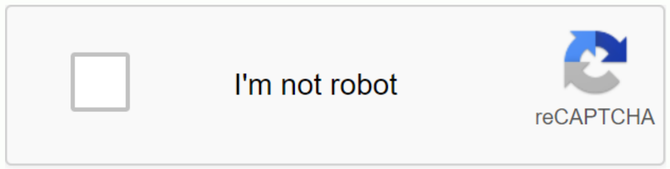

Continue

Statin intensity chart pdf

Decades of research have shown a link between high levels of low density lipoprotein cholesterol (LDL-C) and an increased risk of atherosclerotic cardiovascular disease (ASCVD), including coronary heart disease, stroke and peripheral artery disease. A randomized controlled trial (RCTs) found that treating statins reduces ASCVD events. Based on these data, a group of blood cholesterol experts from the American College of Cardiology (ACC) and the American Heart Association (AHA) released updated evidence-based guidance in 2013 on the use of fixed doses of cholesterol-lowering drugs (statins) to reduce the risk of ASCVD in adults 21 years of age and older. This updated guidance aims at reducing the risk of ASCVD in four groups of statin doses: (1) a person with clinical ASCVD (i.e. acute coronary syndromes or a history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularisation, stroke, transient ischaemic attack or peripheral arterial disease of atherosclerotic origin); (2) persons with a primary increase in LDL-C levels of 190 mg per dl (4,92 mmol per l) or more; (3) persons with diabetes mellitus who are aged 40 to 75 years with LDL-C levels of 70 to 189 mg per dl (1.81 to 4.90 mmol per l) but without clinical ASCVD; and (4) people without clinical ASCVD or diabetes who have LDL-C levels of 70 to 189 mg per dl and an estimated 10-year risk of ASCVD of 7.5% or more. The guidance identifies treatment with high and moderate intensity statins for use in primary and secondary prevention (Table 1). Less evidence is available to support treatment with nestatin in the prevention of ASCVD. NEW LOOK AT TARGETS FOR LDL-C AND/OR NON-HDL-C LEVELS The Panel found no evidence to support the use of high density specific target levels of LDL-C or lipoprotein cholesterol (HDL-C). Although many physicians use target levels (e.g. LDL-C levels below 70 mg per dl for secondary prevention and less than 100 mg per dl [2.59 mmol per l] for primary prevention), evidence has shown that the use of maximum tolerated statin intensity in those who will benefit reduces ASCVD events. No RSCs were found that titrated drug therapy to a specific target level to improve ASCVD results. The use of LDL-C targets could lead to inadequate treatment with evidence-based statin therapy or over-treatment with non-which have not been shown to reduce ASCVD events in RCTs.GLOBAL PRIMARY PREVENTION RISK ASSESSMENT Pooled cohort equations are recommended to estimate the 10-year risk and lifetime risk of ASCVD in white and black adults in order to identify high-risk treatment that will benefit from statin therapy. Physicians and patients should discuss possible benefits, adverse reactions, drug interactions and patient preferences prior to initiation of statin therapy. Absolutely the risk of ascvd events associated with statin therapy can be estimated by multiplying the 10-year risk of ASCVD ASCVD expected reduction in relative risk based on statin intensity (approximately 30% for moderate intensity and 45% for high intensity). The net risk benefit of ASCVD is approximately the number of potential ASCVD events prevented by statin therapy compared to the number of possible excessive adverse events. The panel recognises that those over the age of 70 may have the greatest potential to reduce the risk of using a statin, even without other risk factors. For example, for people in this age group, the estimated 10-year risk is 7.5% or higher, a risk threshold that has been shown to reduce ASCVD events in the NVR. Although evidence supports the continued use of statins older than 75 years in patients who are already inlerant to the medicinal products, limited data were available to support the initiation of statin therapy for primary prevention in patients over 75 years of age without clinical ASCVD. Safety aspects, biomarkers and non-invasive TESTRCT results have identified safety concerns in persons taking statins. To maximize safety in men and women who are not pregnant or breast-feeding, physicians should select an appropriate statin and dose based on patient characteristics, ascvd risk level and potential for adverse reactions. Characteristics that predispose patients to the side effects of statin therapy include, but are not limited to, the following: multiple or severe co-morbidities, such as impaired renal or hepatic function; a history of previous statin intolerance or muscle disorders; unexplained elevated levels of alanine transaminases greater than three times the upper limit of normal; characteristics of the patient or concomitant use of drugs that affect the metabolism of the statin; over the age of 75. Further safety recommendations can be found in Table 8 in the full guidance. In subjects who do not fall into one of the four groups of statin doses, other factors may be considered when deciding on treatment, including primary LDL-C levels of 160 mg per dl (4.14 mmol per l) or higher, or other evidence of genetic hyperlipidaemia; a family history of premature ASCVD 55 years ago in the first degree of male relative or 65 years ago in a firstborn relative; A highly sensitive level of C-reactive protein of 2 mg per l (19,05 nmol per l) or higher; a coronary artery calcium score of 300 agatstone units or more, or less than 0,9 in the 75th index of ankle brachial cells; increased lifetime risk of ASCVD. The recommendations of the Treatment Panel are divided into several main categories and are summarised in Table 2. The algorithm for determining appropriate statin treatment for patients who are candidates for treatment is provided in eFigura A. Specific classes of recommendations, levels of evidence and their definitions are available in full guidance. TREATMENT OBJECTIVES There are no recommendations for or against specific target levels for LDL-C or non-HDL-C primary or secondary prevention of ASCVD. SECONDARY PREVENTION High-intensity statin therapy should be initiated in men and women under 75 years of age who have clinical ASCVD, unless contraindicated. For persons with clinical ASCVD in whom high-intensity statin therapy is contraindicated but otherwise used, or in persons with preispossion properties to statins associated with adverse reactions, moderately intensity statins should be a second option if tolerated. When initiating moderately or high intensity statin therapy in persons over 75 years of age who have clinical ASCVD, it is reasonable to evaluate the potential benefits of risk reduction, adverse reactions and drug interactions. Patient preferences should also be considered. Continued statin treatment is reasonable in people who tolerate it. PRIMARY PREVENTION Secondary causes of hyperlipidaemia should be assessed in persons 21 YEARS OF AGE OR OLDER WITH LDL-C 190 MG DL OR MORE LEVELS OF DL OR MORE WHO HAVE LDL-C levels of 190 mg or more, or triglyceride levels of 500 mg per dl (5.65 mmol per l) or higher. Persons 21 years of age or older who have LDL-C levels of 190 mg per dl or more should be treated with a statin treatment. High intensity statins should be used unless contraindicated. If high-intensity statins are not tolerated, maximum tolerated intensity should be used. In subjects with untreated LDL-C levels of 190 mg per dl or more, statin therapy may be intensified to achieve a minimum 50% reduction in LDL-C. PRIMARY PREVENTION IN PERSONS WITH DIABETES AND LDL-C LEVELS 70 TO 189 MG DL Persons aged 40 to 75 years who have diabetes should start or continue treatment with a medium-intensity statin. In patients with an estimated 10-year risk of ASCVD of 7.5% or higher, high-intensity statin therapy is adequate unless contraindicated. Potential benefits, adverse events, drug interactions and patient preferences should be considered when deciding to initiate, continue or intensify statin therapy in persons under 40 years of age or older. PRIMARY PREVENTION IN PEOPLE WITHOUT DIABETES AND WITH LDL-C LEVELS OF 70 TO 189 MG PER DL Pooled cohort equations should be used to estimate the 10-year risk of ASCVD in subjects without clinical ASCVD in order to guide the initiation of statin therapy. Moderate to high-intensity statin therapy should be used in subjects aged 40 to 75 years without clinical ASCVD or diabetes and with an estimated 10-year risk of ASCVD of 7.5% or higher. If the 10-year risk of ASCVD is 5% to less than 7.5%, moderately intensity statin treatment is appropriate. Before starting statin therapy, it is reasonable for physicians and patients to engage in a discussion on the potential for ASCVD adverse events, events, interactions and preferences of patients. Persons with LDL-C less than 190 mg per dl who do not fall into the group of statin doses or for whom treatment is at risk may be used to inform treatment decisions. Statin therapy may be considered after an evaluation of the potential benefits, adverse events, drug interactions and patient preferences. HEART FAILURE AND HAEMODIALYSIS There are no recommendations for initiating or stopping statin therapy in patients with New York Heart Association Class II to IV ischaemic systolic heart failure or in patients to maintain haemodialysis. Guidance source: American College of Cardiology and American Heart AssociationEvidence evaluation system used? YesLiterature search described? YesGuideline developed by participants without appropriate financial ties to the industry? NoPublished source: Circulation, June 24, 2014As available at: with AAFP qualification, June 2014: 2 Please note: This information was up to date at the time of publication. But medical information is constantly changing, and some of the information listed here may be outdated. Regularly updated information on various health topics can be found at familydoctor.org AAFP for Patients. Am Fam doctor. 2014 August 15;90(4):online. See related article on impetigo. Impetigo (im-puh-TIE-go) is a bacterial infection of the upper layer of the skin. Often it is around the nose or mouth, or somewhere else on the face. It can also be on the legs, hands, or diaper area. Symptoms include: Red ulcers that quickly burst, slime, and then form a yellowish-brown cortexPainless, fluid-filled blistersRecrecomine fever with enlarged lymph nodesImpetigo is most common in children, but adults may also get it. It is more common in hot and humid weather. Overcrowded living conditions and poor hygiene can contribute to getting impetigo. It often starts when bacteria enter the skin through scratches, cuts, or insect ear. It can later spread to healthy skin. Rash impetigo can look like blisters, pain, or burn. You should have your doctor look at the rash and choose how best to treat it. It can be treated with antibiotic ointment or cream such as mupirocin (one brand name: Bactroban) or retapamulin (one brand name: Altabax). If the rash is on a large part of the body, you may need to take antibiotics by mouth. To help control the infection, you should remove all yellow crusts by softening them with soapy water. Antibiotic ointment can work deeper in pain after removal of the cortex. Impetigo is usually treated without scarring. Although it usually disappears on its own for several weeks, treatment is still recommended because it often gets worse before it gets better. Sometimes it can turn into a much more serious skin disease. If the rash changes the appearance of the skin around it, call your doctor. Be completely clean small cuts and abrasions with soap and clean water. You can also use mild antibacterial soap. Since your child can get by touching others who have it and can spread it by scratching it, you should wash the child's hands frequently. Be sure to keep your hands away from the rash and apply antibiotic ointment with a cotton swab. Wash hands after treatment of the rash. Do not share towels. If you are treating an area that is usually shaved, do not shave in that area. You should also throw away shavers that you have recently used. Quickly diagnosing and treating impetigo can reduce the chances of it spreading. To view the full article, sign in or purchase access. This documentation is provided to you by your family doctor and the American Academy of Family Physicians. Further health information is available at AAFP online at . This information provides a general overview and may not apply to everyone. Talk to your family doctor to see if this information applies to you and to learn more about it.