NENC Lipids & FH Pathways & Guidelines:- Interpretation and Application

AHSN-NENC QOF Targets
The Durham Centre
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Disclosures

- Research:- Sanofi, Novartis, Daiichi Sankyo
- Collaborative Working Projects :- Amarin, Novartis, GENinCode
- Advisory:- Amgen, Novartis
- Speaker Fees:- Lilly, Sanofi, Daiichi Sankyo, Amarin, Novartis
- Meeting Sponsorship:- NovoNordisk, Lilly, Sanofi, Boehringer Ingelheim, Amarin

Why develop a Regional Lipid Guideline?

- Historically subregional guidelines (FATS/SLiMS/NEATS)
- Based on NICE - Guidelines (CG 71; 181)
  - Technology Appraisals (TA 385;393;394;)
- Increasingly developing regional approach to Lipid management
  - FH Genetic testing
  - Primary Care FH searches
  - Lipid Optimisation
- Useful to have a single regional resource that we can signpost to for issues pertaining to Lipid Management

What have we learnt?

- Avoided “too much detail” = Secondary Care Guideline
- Single Sheet Summary – stick it on a wall
- Flowcharts – more of the same
- Colour coded sections
  - Ease of access
  - Ease of update
- Developed guidelines to cover the gaps
- Incorporated NICE approved AAC Pathways
- Googleable

Contact with Reality

- Feedback mostly positive
- “Too Complicated”; “Don’t have time to wade through that”
- TA 694; TA 733; TA 805

- Added :-
- Problem based Signposting to relevant section
- Updated Secondary Prevention beyond standard therapy
- Frailty Guidance
- Inclisiran FAQ
- 2023 Version with updates AAC pathway awaiting NTAG approval

Northern England Evaluation and Lipid Intensification guideline

Section Description	Primary Secondary prevention	Statin Intolerance	Severe Hypercholesterolaemia	Severe Hypertriglyceridaemia	Pregnancy	FH in Children and Young People	Supplementary information
Section Guideline			Simon Broome criteria for diagnosis of Familial Hypercholesterolaemia		Lipid management and medication issues in pregnancy		Frailty Guidelines Common drug interactions Lipid Clinic referral criteria Lipoprotein (a) Regional Lipid clinics Inclisiran FAQs
Flow charts	National Guidance for lipid management Secondary prevention treatment beyond standard therapy	Statin intolerance flow chart	Assessment pathway	Assessment pathway		Assessment pathway	

Result based reference guide and link to relevant guideline detail

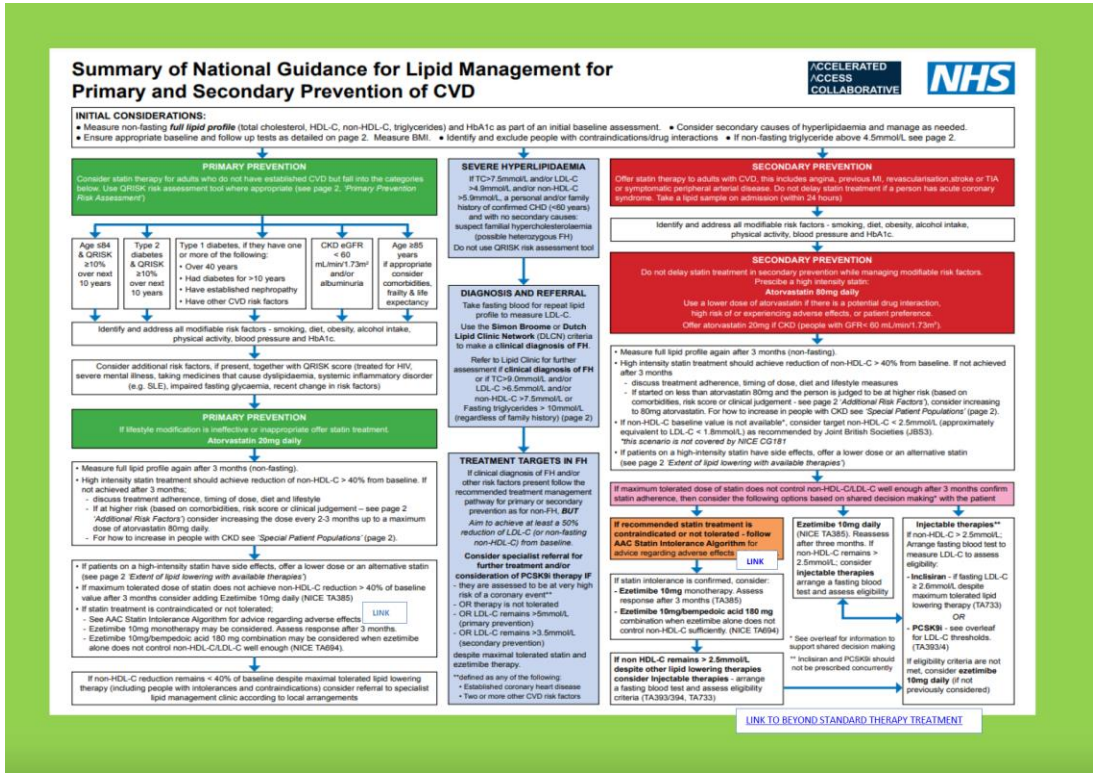
Alternative lipid lowering options - beyond Atorvastatin

Medication	Notes	When to prescribe	Section link
Rosuvastatin	Water soluble statin	First line alternative medication	Red section
Ezetimibe		Additional if non HDLc above target or alternative if statin intolerant	
Ezetimibe + Bempedoic acid	Available as a single tablet	Consider in non HDLc above target on Ezetimibe monotherapy	
Evolocumab/ Alirocumab	Secondary care presciption only	Secondary prevention: single event LDLc>4mmol/l; two or more events LDLc>3.5mmol/l; Familial Hypercholesterolaemia LDLc>5mmol/l	Green section
Inclisiran	Primary or Secondary care prescription	Secondary prevention; LDLc ≥2.6mmol/l	

Guidance related to Interpretation of lipid profile

Parameter	Value	Clinical scenario	Section link
non HDLc	>5.9mmol/l	Assessment for severe hypercholesterolaemia	Peach section
	≥2.5mmol/l	Need to intensify lipid lowering in secondary prevention patients	Green section
Triglycerides	>5mmol/l	Measure fasting lipid profile	Yellow section
Apolipoprotein B100		Measured if fasting triglycerides >10mmol/l	
Total cholesterol	>7.5mmol/l	+ Personal or first degree relative history of IHD/CVD event <60yrs **OR** + First /second degree relative with total cholesterol >7.5mmol/l or LDL>4.9mmol/l **Consider Familial Hypercholesterolaemia**	Peach section
LDLc (fasting lipid profile)	>4.9mmol/l		
Lipoprotein (a)		Consider measuring if personal or first degree relative with history of IHD/CVD <60yrs or lipoprotein (a)>200nmol/l in a first degree relative	Blue section

AAC NICE Approved 1ry/2ry Pathway



Summary of National Guidance for Lipid Management for Primary and Secondary Prevention of CVD

ACCELERATED ACCESS COLLABORATIVE

NHS

INITIAL CONSIDERATIONS:

- Measure non-fasting ***full lipid profile*** (total cholesterol, HDL-C, non-HDL-C, triglycerides) and HbA1c as part of an initial baseline assessment.
- Consider secondary causes of hyperlipidaemia and manage as needed.
- Ensure appropriate baseline and follow up tests as detailed on page 2. Measure BMI.
- Identify and exclude people with contraindications/drug interactions
- If non-fasting triglyceride above 4.5mmol/L see page 2.

PRIMARY PREVENTION

Consider statin therapy for adults who do not have established CVD but fall into the categories below. Use QRISK risk assessment tool where appropriate (see page 2, *'Primary Prevention Risk Assessment'*)

Age ≤84 & QRISK ≥10% over next 10 years	Type 2 diabetes & QRISK ≥10% over next 10 years	Type 1 diabetes, if they have one or more of the following: • Over 40 years • Had diabetes for >10 years • Have established nephropathy • Have other CVD risk factors	CKD eGFR < 60 mL/min/1.73m² and/or albuminuria	Age ≥85 years if appropriate consider comorbidities, frailty & life expectancy

Identify and address all modifiable risk factors - smoking, diet, obesity, alcohol intake, physical activity, blood pressure and HbA1c.

Consider additional risk factors, if present, together with QRISK score (treated for HIV, severe mental illness, taking medicines that cause dyslipidaemia, systemic inflammatory disorder (e.g. SLE), impaired fasting glycaemia, recent change in risk factors)

PRIMARY PREVENTION

If lifestyle modification is ineffective or inappropriate offer statin treatment.
Atorvastatin 20mg daily

- Measure full lipid profile again after 3 months (non-fasting).
- High intensity statin treatment should achieve reduction of non-HDL-C > 40% from baseline. If not achieved after 3 months;
  - discuss treatment adherence, timing of dose, diet and lifestyle
  - If at higher risk (based on comorbidities, risk score or clinical judgement – see page 2 *'Additional Risk Factors'*) consider increasing the dose every 2-3 months up to a maximum dose of atorvastatin 80mg daily.
  - For how to increase in people with CKD see *'Special Patient Populations'* (page 2).
- If patients on a high-intensity statin have side effects, offer a lower dose or an alternative statin (see page 2 *'Extent of lipid lowering with available therapies'*)
- If maximum tolerated dose of statin does not achieve non-HDL-C reduction > 40% of baseline value after 3 months consider adding Ezetimibe 10mg daily (NICE TA385)
- If statin treatment is contraindicated or not tolerated;
  - See AAC Statin Intolerance Algorithm for advice regarding adverse effects LINK
  - Ezetimibe 10mg monotherapy may be considered. Assess response after 3 months.
  - Ezetimibe 10mg/bempedoic acid 180 mg combination may be considered when ezetimibe alone does not control non-HDL-C/LDL-C well enough (NICE TA694).

If non-HDL-C reduction remains < 40% of baseline despite maximal tolerated lipid lowering therapy (including people with intolerances and contraindications) consider referral to specialist lipid management clinic according to local arrangements

SEVERE HYPERLIPIDAEMIA

If TC>7.5mmol/L and/or LDL-C >4.9mmol/L and/or non-HDL-C >5.9mmol/L, a personal and/or family history of confirmed CHD (<60 years) and with no secondary causes: suspect familial hypercholesterolaemia (possible heterozygous FH)
Do not use QRISK risk assessment tool

DIAGNOSIS AND REFERRAL

Take fasting blood for repeat lipid profile to measure LDL-C.

Use the **Simon Broome** or **Dutch Lipid Clinic Network** (DLCN) criteria to make a **clinical diagnosis of FH**.

Refer to Lipid Clinic for further assessment if **clinical diagnosis of FH** or if TC>9.0mmol/L and/or LDL-C >6.5mmol/L and/or non-HDL-C >7.5mmol/L or Fasting triglycerides > 10mmol/L (regardless of family history) (page 2)

TREATMENT TARGETS IN FH

If clinical diagnosis of FH and/or other risk factors present follow the recommended treatment management pathway for primary or secondary prevention as for non-FH, ***BUT***

Aim to achieve at least a 50% reduction of LDL-C (or non-fasting non-HDL-C) from baseline.

Consider specialist referral for further treatment and/or consideration of PCSK9i therapy IF

- they are assessed to be at very high risk of a coronary event**
- OR therapy is not tolerated
- OR LDL-C remains >5mmol/L (primary prevention)
- OR LDL-C remains >3.5mmol/L (secondary prevention)

despite maximal tolerated statin and ezetimibe therapy.

**defined as any of the following:
- Established coronary heart disease
- Two or more other CVD risk factors

SECONDARY PREVENTION

Offer statin therapy to adults with CVD, this includes angina, previous MI, revascularisation,stroke or TIA or symptomatic peripheral arterial disease. Do not delay statin treatment if a person has acute coronary syndrome. Take a lipid sample on admission (within 24 hours)

Identify and address all modifiable risk factors - smoking, diet, obesity, alcohol intake, physical activity, blood pressure and HbA1c.

SECONDARY PREVENTION

Do not delay statin treatment in secondary prevention while managing modifiable risk factors.
Prescibe a high intensity statin:
Atorvastatin 80mg daily
Use a lower dose of atorvastatin if there is a potential drug interaction, high risk of or experiencing adverse effects, or patient preference.
Offer atorvastatin 20mg if CKD (people with GFR< 60 mL/min/1.73m²).

- Measure full lipid profile again after 3 months (non-fasting).
- High intensity statin treatment should achieve reduction of non-HDL-C > 40% from baseline. If not achieved after 3 months
  - discuss treatment adherence, timing of dose, diet and lifestyle measures
  - If started on less than atorvastatin 80mg and the person is judged to be at higher risk (based on comorbidities, risk score or clinical judgement - see page 2 *'Additional Risk Factors'*), consider increasing to 80mg atorvastatin. For how to increase in people with CKD see *'Special Patient Populations'* (page 2).
- If non-HDL-C baseline value is not available*, consider target non-HDL-C < 2.5mmol/L (approximately equivalent to LDL-C < 1.8mmol/L) as recommended by Joint British Societies (JBS3).
  **this scenario is not covered by NICE CG181*
- If patients on a high-intensity statin have side effects, offer a lower dose or an alternative statin (see page 2 *'Extent of lipid lowering with available therapies'*)

If maximum tolerated dose of statin does not control non-HDL-C/LDL-C well enough after 3 months confirm statin adherence, then consider the following options based on shared decision making** with the patient

If recommended statin treatment is contraindicated or not tolerated - follow AAC Statin Intolerance Algorithm for advice regarding adverse effects LINK

If statin intolerance is confirmed, consider:
- **Ezetimibe 10mg** monotherapy. Assess response after 3 months (TA385)
- **Ezetimibe 10mg/bempedoic acid 180 mg** combination when ezetimibe alone does not control non-HDL-C sufficiently. (NICE TA694)

If non HDL-C remains > 2.5mmol/L despite other lipid lowering therapies consider injectable therapies - arrange a fasting blood test and assess eligibility criteria (TA393/394, TA733)

Ezetimibe 10mg daily (NICE TA385). Reassess after three months. If non-HDL-C remains > 2.5mmol/L; consider **injectable therapies** arrange a fasting blood test and assess eligibility

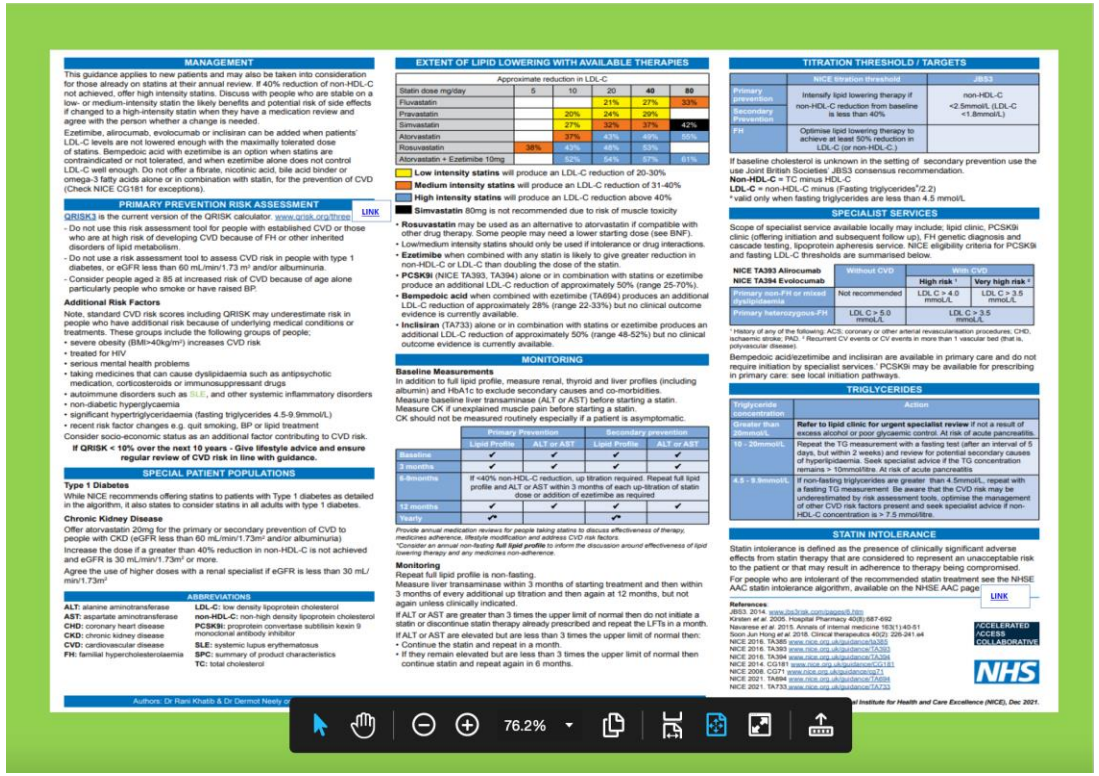
Injectable therapies**
If non-HDL-C > 2.5mmol/L; Arrange fasting blood test to measure LDL-C to assess eligibility:
- **Inclisiran** - if fasting LDL-C ≥ 2.6mmol/L despite maximum tolerated lipid lowering therapy (TA733)
  OR
- **PCSK9i** - see overleaf for LDL-C thresholds. (TA393/4)

If eligibility criteria are not met, consider **ezetimibe 10mg daily** (if not previously considered)

* See overleaf for information to support shared decision making

** Inclisiran and PCSK9i should not be prescribed concurrently

LINK TO BEYOND STANDARD THERAPY TREATMENT



MANAGEMENT

This guidance applies to new patients and may also be taken into consideration for those already on statins at their annual review. If 40% reduction of non-HDL-C not achieved, offer high intensity statins. Discuss with people who are stable on a low- or medium-intensity statin the likely benefits and potential risk of side effects if changed to a high-intensity statin when they have a medication review and agree with the person whether a change is needed.

Ezetimibe, alirocumab, evolocumab or inclisiran can be added when patients' LDL-C levels are not lowered enough with the maximally tolerated dose of statins. Bempedoic acid with ezetimibe is an option when statins are contraindicated or not tolerated, and when ezetimibe alone does not control LDL-C well enough. Do not offer a fibrate, nicotinic acid, bile acid binder or omega-3 fatty acids alone or in combination with statin, for the prevention of CVD (Check NICE CG181 for exceptions).

PRIMARY PREVENTION RISK ASSESSMENT

QRISK3 is the current version of the QRISK calculator. www.qrisk.org/three LINK

- Do not use this risk assessment tool for people with established CVD or those who are at high risk of developing CVD because of FH or other inherited disorders of lipid metabolism.
- Do not use a risk assessment tool to assess CVD risk in people with type 1 diabetes, or eGFR less than 60 mL/min/1.73 m² and/or albuminuria.
- Consider people aged ≥ 85 at increased risk of CVD because of age alone particularly people who smoke or have raised BP.

Additional Risk Factors

Note, standard CVD risk scores including QRISK may underestimate risk in people who have additional risk because of underlying medical conditions or treatments. These groups include the following groups of people;

- severe obesity (BMI>40kg/m²) increases CVD risk
- treated for HIV
- serious mental health problems
- taking medicines that can cause dyslipidaemia such as antipsychotic medication, corticosteroids or immunosuppressant drugs
- autoimmune disorders such as SLE, and other systemic inflammatory disorders
- non-diabetic hyperglycaemia
- significant hypertriglyceridaemia (fasting triglycerides 4.5-9.9mmol/L)
- recent risk factor changes e.g. quit smoking, BP or lipid treatment

Consider socio-economic status as an additional factor contributing to CVD risk.

If QRISK < 10% over the next 10 years - Give lifestyle advice and ensure regular review of CVD risk in line with guidance.

SPECIAL PATIENT POPULATIONS

Type 1 Diabetes

While NICE recommends offering statins to patients with Type 1 diabetes as detailed in the algorithm, it also states to consider statins in all adults with type 1 diabetes.

Chronic Kidney Disease

Offer atorvastatin 20mg for the primary or secondary prevention of CVD to people with CKD (eGFR less than 60 mL/min/1.73m² and/or albuminuria)

Increase the dose if a greater than 40% reduction in non-HDL-C is not achieved and eGFR is 30 mL/min/1.73m² or more.

Agree the use of higher doses with a renal specialist if eGFR is less than 30 mL/min/1.73m²

ABBREVIATIONS

ALT: alanine aminotransferase
AST: aspartate aminotransferase
CHD: coronary heart disease
CKD: chronic kidney disease
CVD: cardiovascular disease
FH: familial hypercholesterolaemia
LDL-C: low density lipoprotein cholesterol
non-HDL-C: non-high density lipoprotein cholesterol
PCSK9i: proprotein convertase subtilisin kexin 9 monoclonal antibody inhibitor
SLE: systemic lupus erythematosus
SPC: summary of product characteristics
TC: total cholesterol

Authors: Dr Rani Khatib & Dr Dermot Neely

EXTENT OF LIPID LOWERING WITH AVAILABLE THERAPIES

Approximate reduction in LDL-C					
Statin dose mg/day	5	10	20	40	80
Fluvastatin			21%	27%	33%
Pravastatin		20%	24%	29%	
Simvastatin		27%	32%	37%	42%
Atorvastatin		37%	43%	49%	55%
Rosuvastatin	38%	43%	48%	53%	
Atorvastatin + Ezetimibe 10mg		52%	54%	57%	61%

Low intensity statins will produce an LDL-C reduction of 20-30%
Medium intensity statins will produce an LDL-C reduction of 31-40%
High intensity statins will produce an LDL-C reduction above 40%
Simvastatin 80mg is not recommended due to risk of muscle toxicity

- **Rosuvastatin** may be used as an alternative to atorvastatin if compatible with other drug therapy. Some people may need a lower starting dose (see BNF).
- Low/medium intensity statins should only be used if intolerance or drug interactions.
- **Ezetimibe** when combined with any statin is likely to give greater reduction in non-HDL-C or LDL-C than doubling the dose of the statin.
- **PCSK9i** (NICE TA393, TA394) alone or in combination with statins or ezetimibe produce an additional LDL-C reduction of approximately 50% (range 25-70%).
- **Bempedoic acid** when combined with ezetimibe (TA694) produces an additional LDL-C reduction of approximately 28% (range 22-33%) but no clinical outcome evidence is currently available.
- **Inclisiran** (TA733) alone or in combination with statins or ezetimibe produces an additional LDL-C reduction of approximately 50% (range 48-52%) but no clinical outcome evidence is currently available.

MONITORING

Baseline Measurements

In addition to full lipid profile, measure renal, thyroid and liver profiles (including albumin) and HbA1c to exclude secondary causes and co-morbidities.
Measure baseline liver transaminase (ALT or AST) before starting a statin.
Measure CK if unexplained muscle pain before starting a statin.
CK should not be measured routinely especially if a patient is asymptomatic.

	Primary Prevention		Secondary prevention	
	Lipid Profile	ALT or AST	Lipid Profile	ALT or AST
Baseline	✔	✔	✔	✔
3 months	✔	✔	✔	✔
6-9months	If <40% non-HDL-C reduction, up titration required. Repeat full lipid profile and ALT or AST within 3 months of each up-titration of statin dose or addition of ezetimibe as required			
12 months	✔	✔	✔	✔
Yearly	✔*		✔*	

Provide annual medication reviews for people taking statins to discuss effectiveness of therapy, medicines adherence, lifestyle modification and address CVD risk factors.
Consider an annual non-fasting **full lipid profile to inform the discussion around effectiveness of lipid lowering therapy and any medicines non-adherence.*

Monitoring

Repeat full lipid profile is non-fasting.
Measure liver transaminase within 3 months of starting treatment and then within 3 months of every additional up titration and then again at 12 months, but not again unless clinically indicated.

If ALT or AST are greater than 3 times the upper limit of normal then do not initiate a statin or discontinue statin therapy already prescribed and repeat the LFTs in a month.

If ALT or AST are elevated but are less than 3 times the upper limit of normal then:
- Continue the statin and repeat in a month.
- If they remain elevated but are less than 3 times the upper limit of normal then continue statin and repeat again in 6 months.

TITRATION THRESHOLD / TARGETS

	NICE titration threshold	JBS3
Primary prevention	Intensify lipid lowering therapy if non-HDL-C reduction from baseline is less than 40%	non-HDL-C <2.5mmol/L (LDL-C <1.8mmol/L)
Secondary Prevention		
FH	Optimise lipid lowering therapy to achieve at least 50% reduction in LDL-C (or non-HDL-C)	

If baseline cholesterol is unknown in the setting of secondary prevention use the use Joint British Societies' JBS3 consensus recommendation.
Non-HDL-C = TC minus HDL-C
LDL-C = non-HDL-C minus (Fasting triglycerides*/2.2)
* valid only when fasting triglycerides are less than 4.5 mmol/L

SPECIALIST SERVICES

Scope of specialist service available locally may include; lipid clinic, PCSK9i clinic (offering initiation and subsequent follow up), FH genetic diagnosis and cascade testing, lipoprotein apheresis service. NICE eligibility criteria for PCSK9i and fasting LDL-C thresholds are summarised below.

NICE TA393 Alirocumab NICE TA394 Evolocumab	Without CVD	With CVD	
		High risk [1]	Very high risk [2]
Primary non-FH or mixed dyslipidaemia	Not recommended	LDL C > 4.0 mmol/L	LDL C > 3.5 mmol/L
Primary heterozygous-FH	LDL C > 5.0 mmol/L	LDL C > 3.5 mmol/L	

[1] History of any of the following: ACS; coronary or other arterial revascularisation procedures; CHD; ischaemic stroke; PAD. [2] Recurrent CV events or CV events in more than 1 vascular bed (that is, polyvascular disease).

Bempedoic acid/ezetimibe and inclisiran are available in primary care and do not require initiation by specialist services.' PCSK9i may be available for prescribing in primary care: see local initiation pathways.

TRIGLYCERIDES

Triglyceride concentration	Action
Greater than 20mmol/L	**Refer to lipid clinic for urgent specialist review** if not a result of excess alcohol or poor glycaemic control. At risk of acute pancreatitis.
10 - 20mmol/L	Repeat the TG measurement with a fasting test (after an interval of 5 days, but within 2 weeks) and review for potential secondary causes of hyperlipidaemia. Seek specialist advice if the TG concentration remains > 10mmol/litre. At risk of acute pancreatitis
4.5 - 9.9mmol/L	If non-fasting triglycerides are greater than 4.5mmol/L, repeat with a fasting TG measurement .Be aware that the CVD risk may be underestimated by risk assessment tools, optimise the management of other CVD risk factors present and seek specialist advice if non-HDL-C concentration is > 7.5 mmol/litre.

STATIN INTOLERANCE

Statin intolerance is defined as the presence of clinically significant adverse effects from statin therapy that are considered to represent an unacceptable risk to the patient or that may result in adherence to therapy being compromised.

For people who are intolerant of the recommended statin treatment see the NHSE AAC statin intolerance algorithm, available on the NHSE AAC page. LINK

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NICE 2008. CG71 www.nice.org.uk/guidance/cg71
NICE 2021. TA694 www.nice.org.uk/guidance/TA694
NICE 2021. TA733 www.nice.org.uk/guidance/TA733

ACCELERATED ACCESS COLLABORATIVE

NHS

76.2%

Basically……

- Measure full fasted lipid profile and assess risk
- Address Secondary causes / Lifestyle issues

- Primary Prevention
  - Atorvastatin 20 mg OD
  - Aim for 40% reduction from baseline NonHDL-C
  - Up titrate and add Ezetimibe if not to target

- Secondary Prevention
  - Atorvastatin 80 mg OD (start with 20mg if eGFR < 60 or interaction)
  - Aim for NonHDL-C < 2.5 mmol/L [or LDL < 1.8 mmol/L]
  - Consider additional therapy if eligible

Grouping of Statins

	Reduction in LDL				
Dose mg / day	5	10	20	40	80
Fluvastatin			21%	27%	33%
Pravastatin		20%	24%	29%	
Simvastatin		27%	32%	37%	42% MRHA
Atorvastatin		37%	43%	49%	55%
Rosuvastatin	38%	43%	48%	53%	
Atorvastatin + Ezetimibe		52%	54%	57%	61%

NICE QOF Indicators

CHOL 001 = 14 Points 70-95%

% CHD, PAD, CVA/TIA or CKD prescribed statin or alternative lipid lowering therapy

CHOL 002 = 16 Points 20-35%

% CHD, PAD, CVA/TIA with NonHDL < 2.5 or LDL < 1.8 mmol/l

DM022 = 4 Points 50-90%

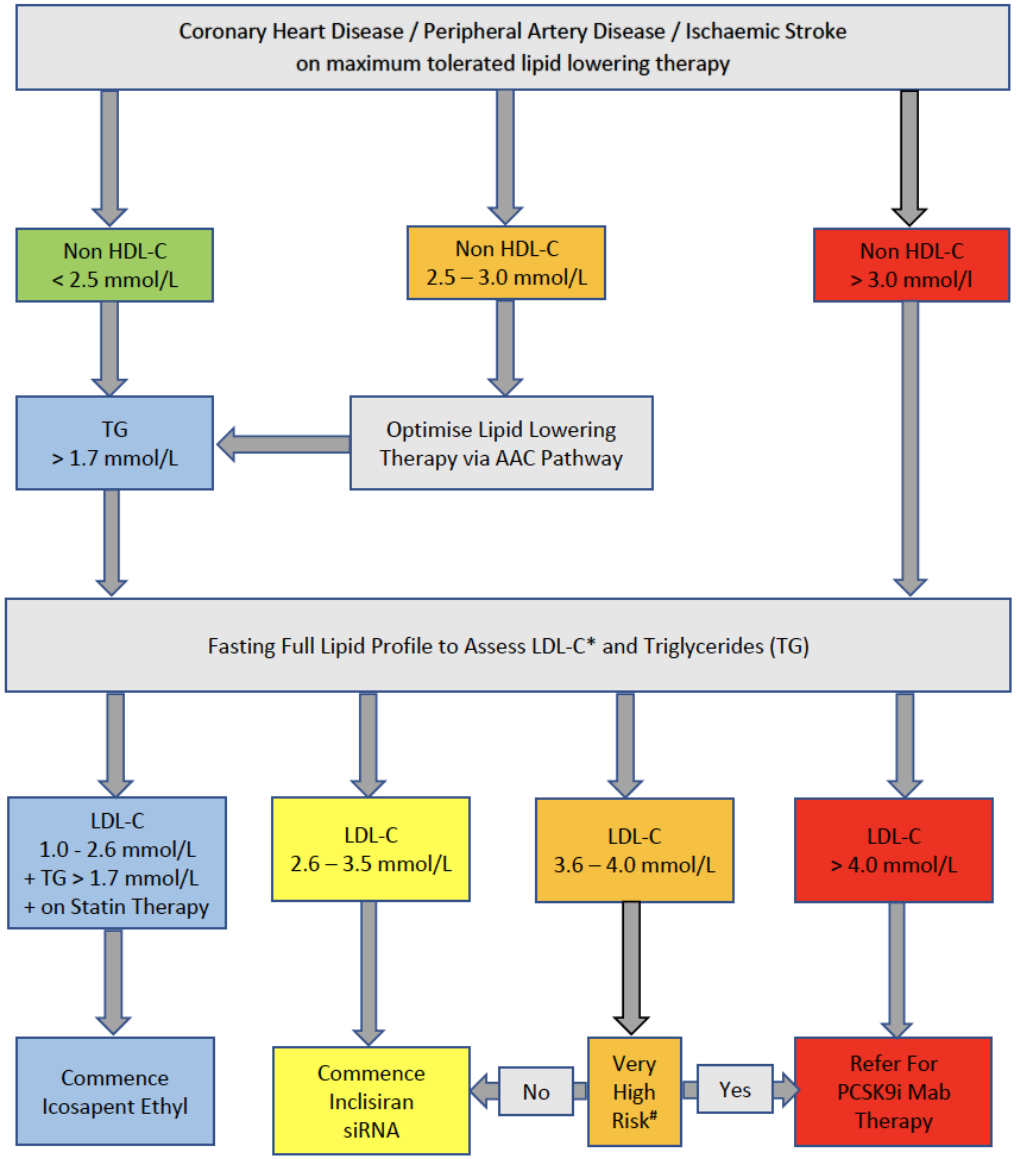
% Patients with DM >40yr without CVD or mod/severe Frailty prescribed statin

(exclude T2DM with QRisk < 10%)

DM023 = 2 Points 50-90%

% Patients with DM with CVD (excl haemorrhagic stroke) prescribed statin

Secondary Prevention Beyond Standard Therapy



Measure Fasting LDL if CVD + NonHDL not to target

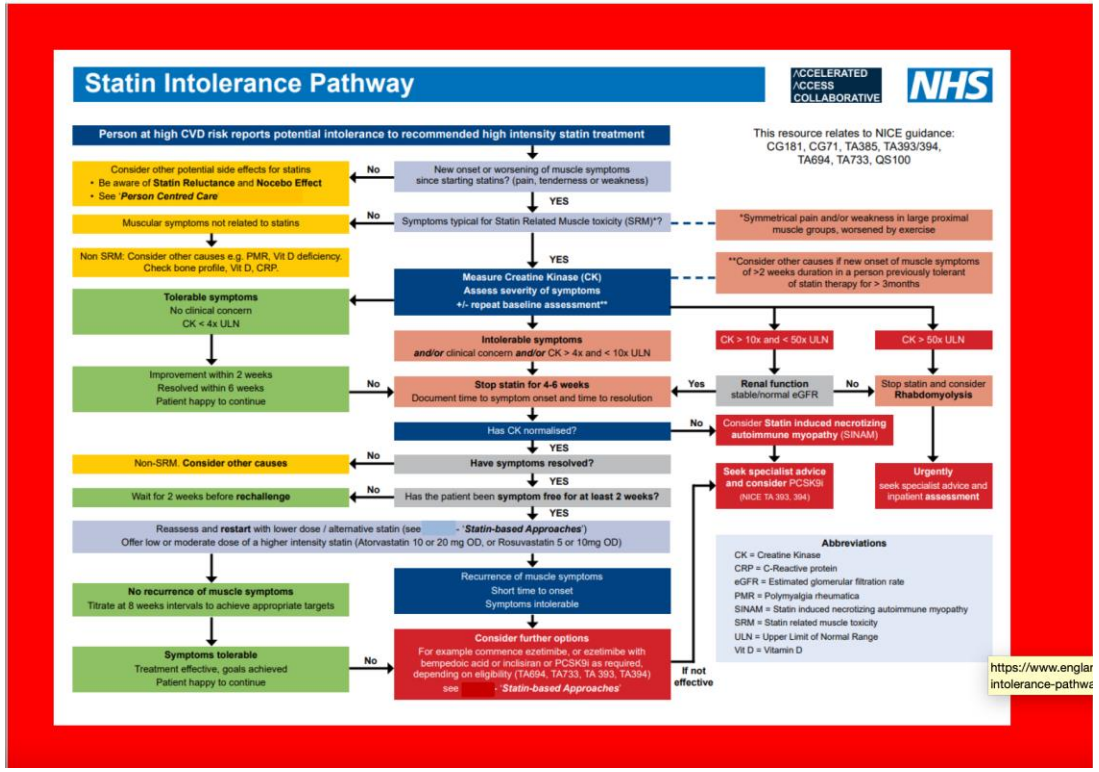
- Non HDL < 2.5 mmol/L
  - To Target; Consider Vazkepa if TG > 1.7mmol/L and LDL 1.0 – 2-6 mmol/L

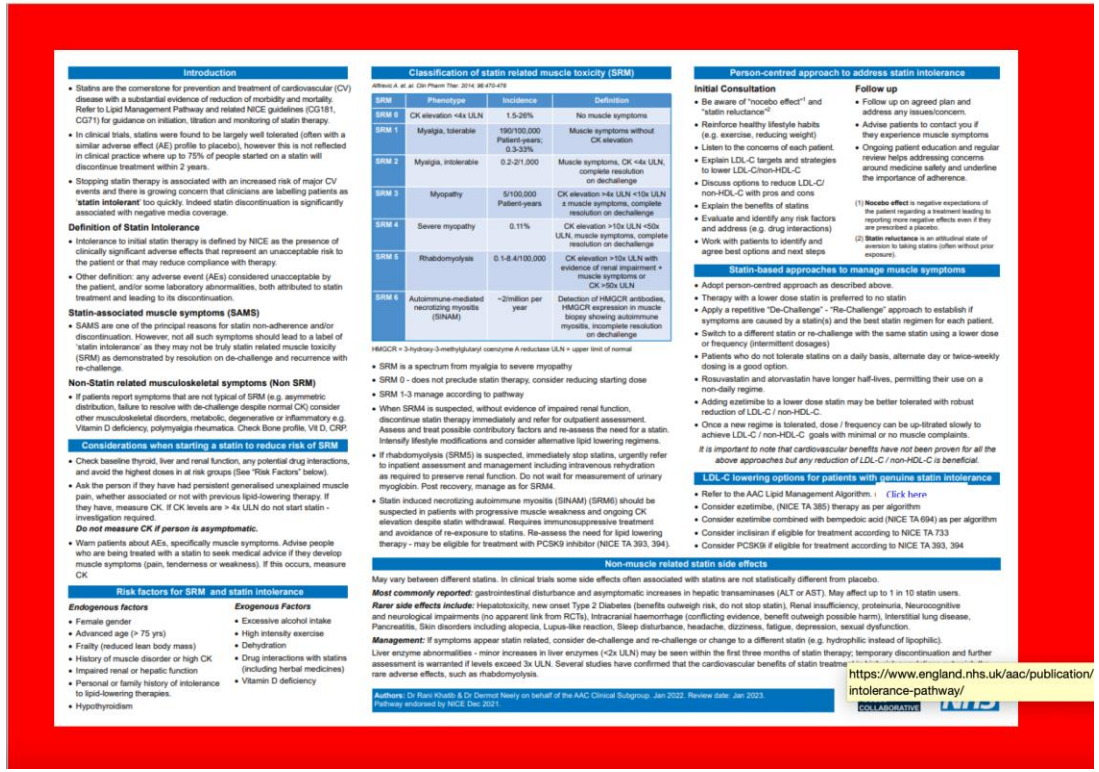
- Non HDL 2.5 – 3.0 mmol/L
  - Optimise Statin / Ezetimibe therapy
  - Consider Vazkepa if TG > 1.7mmol/L and LDL 1.0 – 2-6 mmol/L

- NonHDL ≥ 3.0 mmol/L

- LDL > 4.0 mmol/L	→	Refer for PCSK9i MaB
- LDL > 3.5 mmol/L	→	Refer for PCSK9i MaB if Very High Risk
	→	Start Inclisiran if High Risk
- LDL > 2.6 mmol/L	→	Start Inclisiran
- LDL = 1.0 – 2.6 mmolL	→	Consider Vazkepa if TG > 1.7mmol/L

AAC Statin Intolerance Pathway





Statin Intolerance

- Affects up to 10% of patients
- Significant nocebo effect :- reinforced by health professionals
- More likely in certain subgroups (female, hypothyroid, alcohol excess)
- Ask, reassure, advise
- Check Creatinine Kinase if symptoms suggestive of myalgia

- Aim for max tolerated dose (low better than no)
- Re-try at lower dose after 4-6 week wash out period
- Switch to Rosuvastatin 10 mg
- Consider lower intensity statin
- Use Ezetimibe as statin sparing agent or as monotherapy
- Consider addition of Bempedoic acid to Ezetimibe if NonHDL

Additional Sections

- Severe Hypercholesterolaemia
  - Simon Broome criteria
  - Pathway
- Severe Hypertriglyceridaemia
  - Use of Apo B100 alongside Full Fasted Lipid Profile
- Pregnancy
- FH in Children and Young People
- Supplementary
  - Frailty
  - Common Drug Interactions
  - Lipid Clinic Referral Criteria
  - Lipoprotein (a)
  - Regional Lipid Clinics
  - Inclisiran FAQ

FH Diagnosis

Simon Broome Criteria

1. Total Chol > 7.5 or LDL > 4.9
2. Tendon Xanthoma

3. Family history of Premature MI*
4. Family history of hypercholesterolaemia@

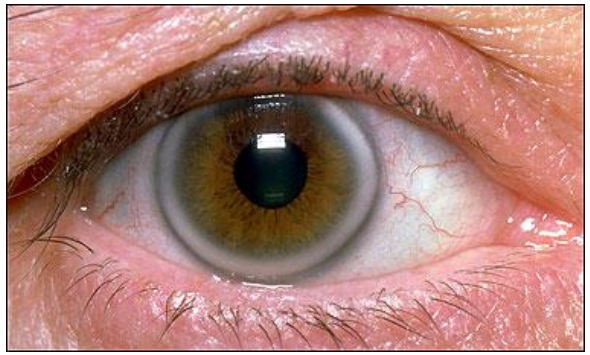
* <60 yr if 1^{O} Rel or < 50 yr 2^{O} Rel

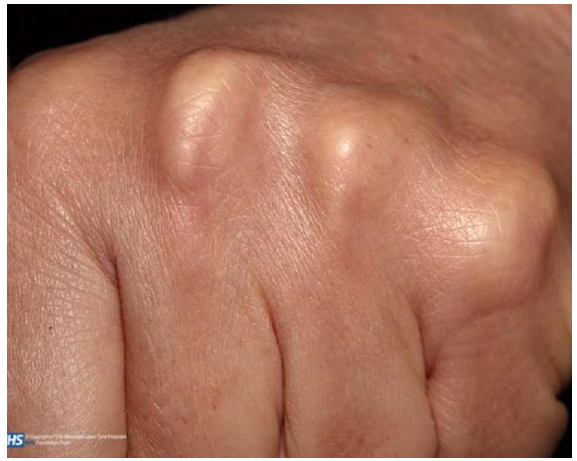
@ Total Chol > 7.5 or LDL > 4.9 in 1^{O} / 2^{O} Rel

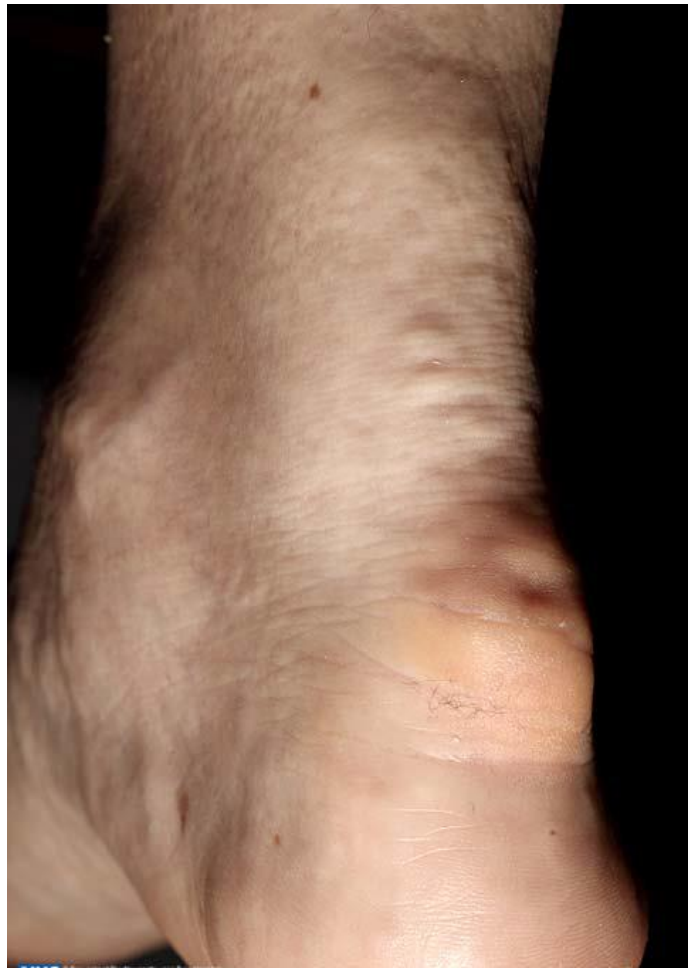
1+2 = Definite FH

1+ 3 or 4 = Probable FH

Dutch Lipid Clinic Network score ≥6 used to determine whether or not to do genetic testing







Referring FH

- Use Simon Broom Criteria to determine whether “could” have FH
  - 1 in 250 patients have FH = 0.4%
  - Population with Chol > 7.5 mmol/l = 4%
  - Hypercholesterolaemia common in women > 50 yrs

- Don’t use DLCS; determines whether eligible for genetic testing
  - LDL > 6.4 mmol/L + family history premature MI / LDL > 5.5 mmol/L
  - LDL > 4.9 + personal MI < 60 yr + family history
  - Bilateral TX
  - TG < 2.3 mmol/L

- Refer via A+G if
  - > 30 yr with Chol > 9.0 mmol/L or NonHDL > 7.5 mmol/l or LDL > 6.5 mmol/L
  - < 30 yr with Chol > 7.5 mmol/L or NonHDL > 6.0 mmol/l or LDL > 4.9 mmol/L

Criteria for Lipid Clinic Referral

- All Regional Lipid Clinics offer A+G
- Refer if
- Clinical Diagnosis of FH according to SB criteria
  - Relatives who require genetic testing (FH Nurses)
  - Children with FH (Paediatric Clinic)
- Total Chol > 9.0 mmol/L or NonHDL-C > 7.5 mmol/L
- TG > 10 mmol/L (Urgently if > 20 mmol/L)
- Other Lipid disorders (Remnant / FCH / Familial HyperTG)
- Patients with CVD and NonHDL-C > 4 mmol/L
- Patients for PCSK9i Mab therapy

Where can I find it?

- NTAG Website

https://ntag.nhs.uk/wp-content/uploads/2022/09/NEELI-edit-v2022.2-FINAL-NTAG.pdf

- 2023 update awaiting NTAG approval
- Update existing weblinks

Any Questions?