Health Innovation
North East and North Cumbria

CVD lunch and learn session - What do the lipid guidelines say these days, and where do I start?

30th January 2024 12.15 – 13.00, Online

House Keeping

- Please ensure your microphone and video are turned off during the session. This is to avoid any disruption during presentations and to assist with the quality of the connection.
- If you need to take a break, please feel free to drop off the call at any time and re-join.
- Live captions are available if required.
- The event is being recorded and will be shared.
- Please ask any questions you have through the chat facility. We will try to address questions during the event, but if we don't manage to do this we will follow up after the event.
- If you cannot see the chat, please email your question/s to sarah.black@healthinnovationnenc.org.uk

The Health Innovation Network

The Academic Health Science Network for the North East and North Cumbria has changed its name to Health Innovation North East and North Cumbria (HI NENC).

The new name – which came into effect on 1st October following the start of our new five-year licence – reflects the organisation's key role to continue to support the development and spread of innovation across the region's health service.

But while our name has changed, our vision remains the same: to improve health outcomes, reduce inequalities, and boost the regional economy. Working alongside partners across the system, we will continue to accelerate health innovation in the region, and beyond.

Established in 2013 by NHS England we are one of 15 Health Innovations.

www.healthinnovationnenc.org.uk

Health Innovation
North East and North Cumbria

Agenda

12:15pm: Welcome

12:20pm: Barry Todd – what does QOF say about Lipids and why?

12:35pm: Dr Stewart Pattman and Dr Su- Anne Tee – NEELI made easy

12:50pm: Questions and open discussion

1:00pm: Close

What does QOF say about lipids and why?

Barry Todd,

Pharmacist Practitioner

Village Green Surgery

- **Why?**
- Cholesterol targets were ousted from QOF targets for a number of years.
- Why have they returned? Simply because of the enormity of the prevalence and consequences of Cardiovascular Disease (CVD)
- The second highest cause of death in E&W (2022) - Ischemic Heart Disease 10.3% of all deaths (4.2% increase from 2021)
- The fourth highest - Stroke - 5.1% of all deaths (0.8% increase from 2021)
- CVD causes one death every 3 minutes in the UK and those in the most deprived areas are 4x more like to die prematurely from CVD.
- YOU CAN MAKE A DIFFERENCE! By lowering 'bad cholesterol' by 1mmol/l you can help reduce the incidence of a major CV event by 23%

How?

Achievement

Indicator	Points	Threshold
CHOL001. Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, Stroke/TIA or Chronic Kidney Disease Register who are currently prescribed a statin, or where a statin is declined or clinically unsuitable, another lipid-lowering therapy	**14**	**70 – 95%**
CHOL002. Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, or Stroke/TIA Register, who have a recording of non-HDL cholesterol in the preceding 12 months that is lower than 2.5 mmol/L, or where non-HDL cholesterol is not recorded a recording of LDL cholesterol in the preceding 12 months that is lower than 1.8 mmol/L	**16**	**20 – 35%**

CHOL001 - 70-95%

Challenging target for a reason

Quick wins before March 31st:-

- Ardens QOF indicators - calculate your shortfall
- Run searches ‘CVD not on LLT’ - exception code if declined or not tolerated
- If neither ‘declined’ nor ‘not tolerated’ then arrange a review to discuss and where appropriate prescribe a statin or other appropriate LLT
- Offer any with diagnosed CKD a statin or oral alternative.

How Am I Driving? (28-Jan-2024) | 1m Lookahead (26-Feb-2024) | End of QMAS Year (31-Mar-2024)

Name	Population C...	%	Targ...	Points	Last Run	Search Type
Cholesterol Denominator Populations						
CHOLREG - Patients with CHD / PAD / TIA or ≥18 with C...	983	8%			29-Jan-2024	Patient
CHOL2REG - Patients with CHD / PAD / TIA	718	6%			29-Jan-2024	Patient
CHOL001 - Patients with CHD / PAD / TIA / CKD on stati...	**549**	**85%**	**95%**	**8.39/14**	29-Jan-2024	Patient
CHOL002 - Patients with non-HDL cholesterol <2.5 or LD...	307	44%	35%	16/16	29-Jan-2024	Patient

CHOL001 - Patients with CHD / PAD / TIA / CKD on statin/lipid-lowering therapy

Details | Definition | Age / Sex | Trend | Population Included | Population Excluded

Description **Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, Stroke/TIA or Chronic Kidney Disease Register who are currently prescribed a statin, or where a statin is declined or clinically unsuitable, another lipid-lowering therapy.**

Parent Population **[CHOL001] - Patients with CHD / PAD / TIA / CKD on statin/lipid-lowering therapy**

Parent Folder **Cholesterol Denominator Populations**

Code System **N/A**

Author **Emis** Date Modified **12-Jan-2024**

Last Run **29-Jan-2024 04:13** Relative Date **28-Jan-2024**

Population Count	Parent	%	Excluded
549	646	85%	97

CHOL002 - 20-35%

Don’t be deceived - don’t assume

Quick wins before March 31st

- Look at your shortfall
- Run search for all on a Vascular Register identifying their last cholesterol test date and level.
- If last date before April 1st 2023 - then get them in for a lipid profile (and LFTs)
- If prescribed a new dose of LLT and have failed to have their 3-month lipid profile (and LFTs) then invite them in.
- If non-HDLc 2.5 (LDLc 1.8) or more then intensify treatment in next week or so and repeat bloods just before end of March. An 8 week test ought to show a significant drop in non-HDLc.
- Go for low hanging fruit. Those with their last non-HDLc of 2.5 to 3.0 are likely to get to target by intensifying their LLT regime.

NICE NG238 - a cause for confusion?

NEELI and QOF base their target on clinical evidence (as do ESC and ACA) - non-HDLc <2.5 or LDLc <1.8
NICE base their target on cost effective (more bangs for your bucks) model. - non-HDLc of 2.6 (that is <2.7) or LDLc 2.0 (that is <2.1)

Both NEELI and NICE both agree that more lipid intensification is better that using Atorvastatin 80mg alone.
NICE would say Atorvastatin 80mg plus ezetimibe routinely regardless of level achieved by Atorvastatin 80mg alone. Then tweak if necessary.
NEELI would say Atorvastatin 80mg and what you add in after that would depend on your non-HDLc - if > 3.1 - consider Inclisiran; if 3.1 to 2.5 then add in ezetimibe

Cautionary notes

- QOF target remains at non-HDLc <2.5 until we hear otherwise
- Be familiar with the NEELI guidelines and always use the latest version
- Never file off your lipid profiles without looking at the non-HDLc or LDLc to check whether it is to target. Don’t be taken in by the default ‘normal/normal for patient’ comment on the lab report.
- If your patient has a total cholesterol of 7.5 or more then consider the possibility of Familial Hypercholesterolaemia - again following the NEELI guidelines. Where targets cannot be reached using the LLT’s available to Primary Care then it may involve a referral into your local Lipid Clinic where a PCSK9-i injection may need to prescribed.

Q&A session

- Any questions?

NEELI – made easy

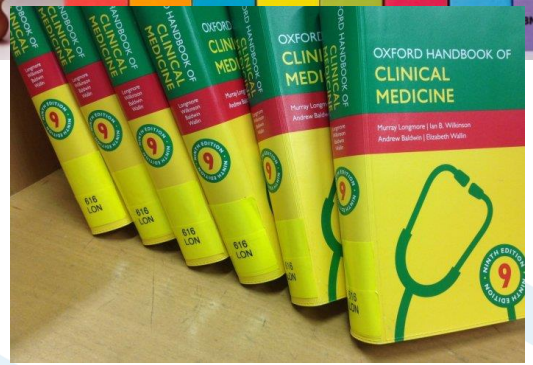
Dr Stewart Pattman, Consultant Chemical Pathologist, Northumbria, and

Dr Su-Ann Tee, Consultant Endocrinologist, Gateshead

NEELI – made easy

Section Description	Primary & Secondary prevention	Statin Intolerance	Severe Hypercholesterolaemia or ? Familial Hypercholesterolaemia	Assessment of 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	

Dip in and out, cover-to-cover detail not required!



NEELI key sections

Primary & Secondary Prevention	Initiation criteria, targets, escalation steps
Statin intolerance	Pathway, definitions, options
Severe Hypercholesterolaemia >7.5mmol/l	Simon Broome criteria for Familial Hypercholesterolaemia
Hypertriglyceridaemia	Secondary causes, assessment, treatment, referral

Pregnancy

FH in Children

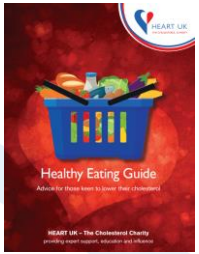
Other: Frailty, drug interactions, lipoprotein (a), lipid clinic referral criteria

Primary & Secondary Prevention

Scenario 1

- Mr A, 53yr old
- MI aged 52
- Atorvastatin 80mg
- Lifestyle: low cholesterol diet

NON FASTING LIPID PROFILE	mmol/l
Cholesterol	5.9
Triglyceride	1.4
HDL cholesterol	1.2
Non HDL cholesterol	4.7

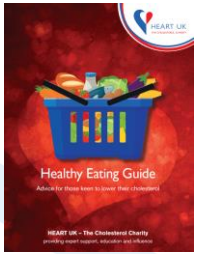


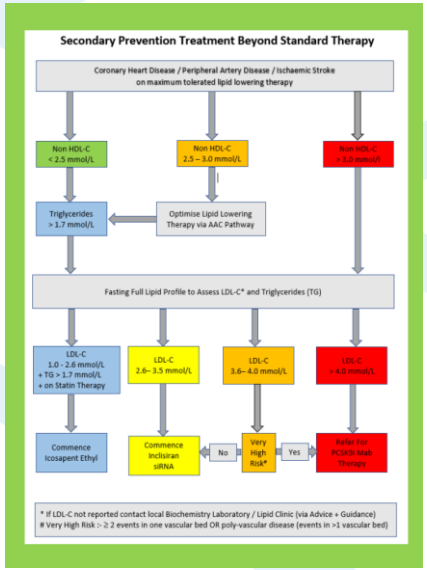
https://www.heartuk.org.uk/downloads/health-professionals/publications/healthy-eating-guide.pdf

Primary & Secondary Prevention

Scenario 1

- Mr A, 53yr old
- MI aged 52
- Atorvastatin 80mg
- Lifestyle: low cholesterol diet





NON FASTING LIPID PROFILE	mmol/l
Cholesterol	5.9
Triglyceride	1.4
HDL cholesterol	1.2
Non HDL cholesterol	4.7

FASTING LIPID PROFILE	mmol/l
Cholesterol	5.8
Triglyceride	1.2
HDL cholesterol	1.0
LDL cholesterol	4.3
Non HDL cholesterol	4.8

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Primary & Secondary Prevention

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- MI aged 52
- Atorvastatin 80mg
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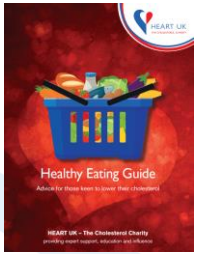

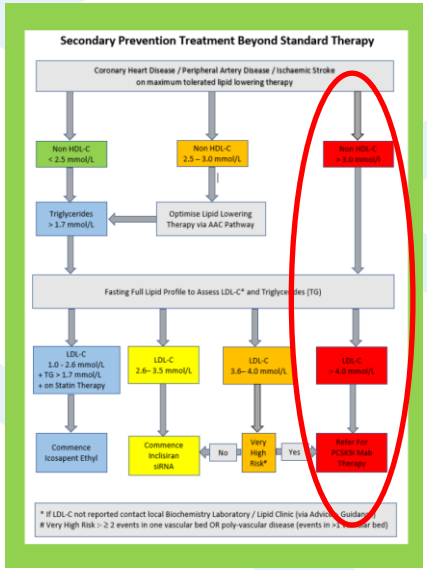

NON FASTING LIPID PROFILE	mmol/l
Cholesterol	5.9
Triglyceride	1.4
HDL cholesterol	1.2
Non HDL cholesterol	4.7

FASTING LIPID PROFILE	mmol/l
Cholesterol	5.8
Triglyceride	1.2
HDL cholesterol	1.0
LDL cholesterol	4.3
Non HDL cholesterol	4.8

Action: refer to lipid clinic for PCSK9i fortnightly self injections alongside statin

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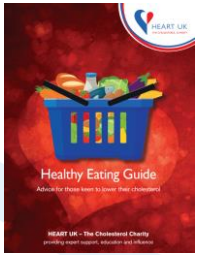
https://www.heartuk.org.uk/downloads/health-professionals/publications/healthy-eating-guide.pdf

Primary & Secondary Prevention

Scenario 2

- Mr A, 53yr old
- MI aged 52
- Atorvastatin 80mg
- Lifestyle: low cholesterol diet

NON FASTING LIPID PROFILE	mmol/l
Cholesterol	4.5
Triglyceride	1.2
HDL cholesterol	1.0
Non HDL cholesterol	3.5



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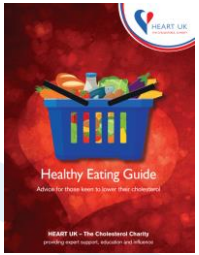
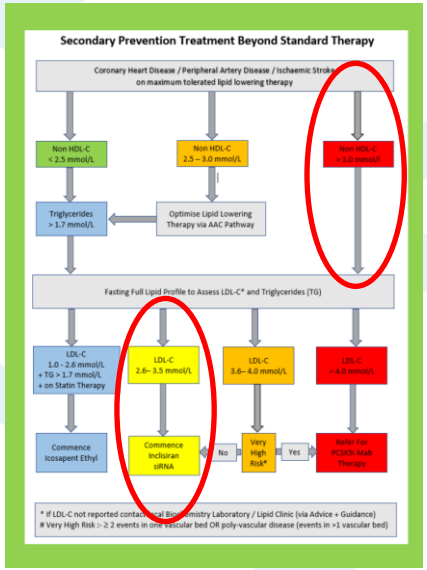
Primary & Secondary Prevention

Scenario 2

- Mr A, 53yr old
- MI aged 52
- Atorvastatin 80mg
- Lifestyle: low cholesterol diet





NON FASTING LIPID PROFILE	mmol/l
Cholesterol	4.5
Triglyceride	1.2
HDL cholesterol	1.0
Non HDL cholesterol	3.5

FASTING LIPID PROFILE	mmol/l
Cholesterol	4.4
Triglyceride	1.2
HDL cholesterol	1.0
LDL cholesterol	2.9
Non HDL cholesterol	3.4

Action: Can be offered Inclisiran 284mg sc injections (2 three months apart then 6 monthly) in addition to statin

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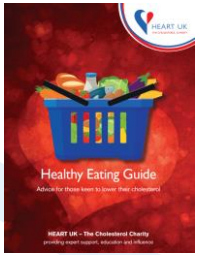
Primary & Secondary Prevention

Scenario 3

- Mr A, 53yr old
- MI aged 52
- Atorvastatin 10mg & Ezetimibe 10mg
- Lifestyle: low cholesterol diet

NON FASTING LIPID PROFILE	mmol/l
Cholesterol	4.0
Triglyceride	1.2
HDL cholesterol	1.3
Non HDL cholesterol	2.7



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Use of Bempedoic acid

Most patients will add Bempedoic acid to Ezetimibe monotherapy

SPC	in combination with a statin or statin with other lipid-lowering therapies in patients unable to reach LDL-C goals with the maximum tolerated dose of a statin *Contraindication: Concomitant use with simvastatin>40mg daily*
BNF	Primary hypercholesterolaemia or mixed dyslipidaemia in patients who have not responded adequately to other appropriate measures *[in combination with a statin, or with a statin and other lipid-lowering therapies, or with other lipid-lowering therapies or alone if a statin contra-indicated or not tolerated]*
NICE TA 694	Bempedoic acid with ezetimibe is recommended as an option for treating primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia as an adjunct to diet in adults. It is recommended only if: statins are contraindicated or not tolerated

CLEAR Outcomes: unable to tolerate statin apart from average dose <10mg Atorvastatin, <40mg Pravastatin, <5mg Rosuvastatin

Definitions of statin intolerance may not reflect clinical practice.

Use of Bempedoic acid

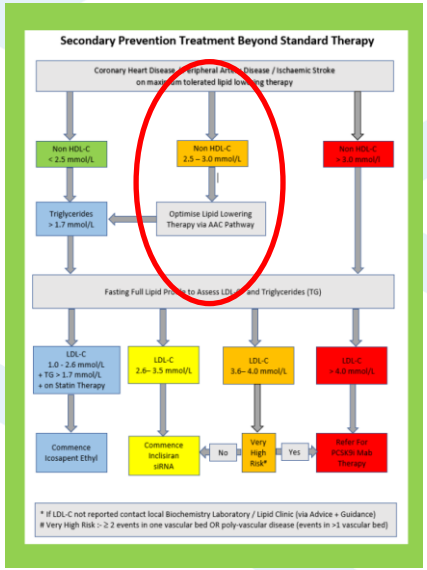
- High CV risk (secondary prevention/genetic lipid diagnosis)
  - Ineligible for injectable lipid lowering therapy
  - Tolerate low dose statin (10mg Atorvastatin/5mg Rosuvastatin)
  - Tolerate Ezetimibe 10mg
  - Add in Bempedoic acid 180mg OD

Primary & Secondary Prevention

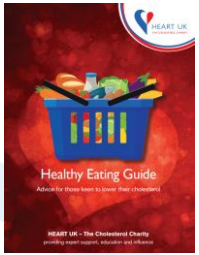
Scenario 3

- Mr A, 53yr old
- MI aged 52
- Atorvastatin 10mg & Ezetimibe 10mg
- Lifestyle: low cholesterol diet

NON FASTING LIPID PROFILE	mmol/l
Cholesterol	4.0
Triglyceride	1.2
HDL cholesterol	1.3
Non HDL cholesterol	2.7



Action: Consider offering Bempedoic Acid 180mg OD alongside statin and ezetimibe



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Severe Hypercholesterolaemia >7.5mmol/l

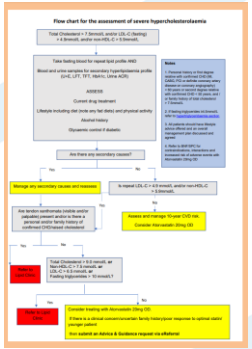
Scenario 4

- Mrs B, 49 yr old
- Primary prevention
- Health check blood test

NON FASTING LIPID PROFILE	mmol/l
Cholesterol	8.4
Triglyceride	1.2
HDL cholesterol	1.8
Non HDL cholesterol	6.6

Fasting lipid profile to confirm cholesterol >7.5mmol/l (or LDLc >4.9)

ACTIONS



1) EXCLUDE secondary causes
- Diet: Restrictive e.g. keto
- Alcohol/diabetes/thyroid/liver/nephrotic syndrome

2) COMPARE to previous lipids
- Rises or large changes could point towards secondary cause
- Consider effect of menopause – review historical levels

3) SPECIFY Family History
- MI (IHD) <60yrs in first degree relative / <50yrs in second degree
- OR Cholesterol >7.5mmol/l in first degree relative

Other options
Advise siblings/adult offspring to check cholesterol to see if >7.5mmol/l

If **Fasting** lipid profile & Family history meets criteria
> Refer to lipid clinic
If not – risk assessment could be aided by using QRISK3 org.uk

Hypertriglyceridaemia

Scenario 5

- Mr C, 53yr old
- Incidental finding

NON FASTING LIPID PROFILE	
Cholesterol/mmol/l	9.2
Triglyceride/mmol/l	18.2
HDL cholesterol/mmol/l	NA
Non HDL cholesterol/mmol/l	NA
HbA1c/mmol/mol	41
TSH/U/l	1.6

Hypertriglyceridaemia

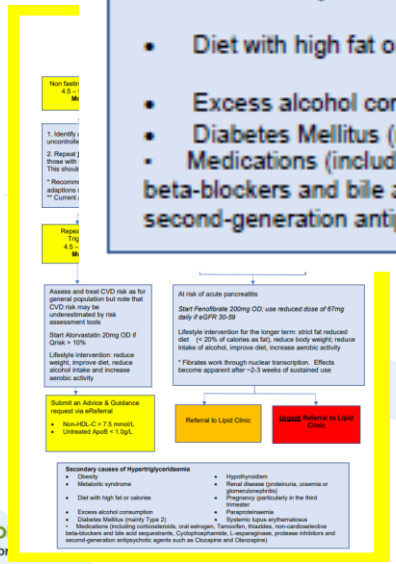
Scenario 5

- Mr C, 53yr old
- Incidental finding

NON FASTING LIPID PROFILE	
Cholesterol/mmol/l	9.2
Triglyceride/mmol/l	18.2
HDL cholesterol/mmol/l	NA
Non HDL cholesterol/mmol/l	NA
	.
	5

Secondary causes of Hypertriglyceridaemia

- Obesity
- Metabolic syndrome
- Diet with high fat or calories
- Excess alcohol consumption
- Diabetes Mellitus (mainly Type 2)
- Hypothyroidism
- Renal disease (proteinuria, uraemia or glomerulonephritis)
- Pregnancy (particularly in the third trimester
- Paraproteinaemia
- Systemic lupus erythematosus
- Medications (including corticosteroids, oral estrogen, Tamoxifen, thiazides, non-cardioselective beta-blockers and bile acid sequestrants, Cyclophosphamide, L-asparaginase, protease inhibitors and second-generation antipsychotic agents such as Clozapine and Olanzapine)



safety net

2 protein B (aim <2 weeks)

3
- Fenofibrate 200mg OD if Trigs>10mmol/l
- Referral to lipid clinic if no secondary causes

Q&A time

- Any questions?

Upcoming events…

Chronic Kidney Disease Webinar, 7 Mar 12-1pm

This session will cover:

- What is CKD?
- The importance of CKD as a cardiovascular risk factor;
- resources for practices to support the implementation of the North East and North Cumbria renal Operational Delivery Network Guidance for CKD

Chaired by Julia Newton, speakers include **Dr Sarah McCloskey** Consultant Nephrologist at South Tyneside and Sunderland NHS FT and CKD Lead for NHS England NENC Renal Operational Delivery Network NENC and **Prof Raj Thakkar**, GP, Bourne End and Wooburn Green Medical Centre and Primary Care Cardiology lead, Oxford AHSN, Honorary Visiting Professor, Cardiff University Medical School | President and CKD lead, PCCS, National primary care workstream co-lead, Cardiac Transformation Programme, NHS England and Improvement.

SCAN ME

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