



Guidelines

Volume 37

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Welcome to the 37th edition of **Guidelines**, the three-times yearly handbook summarising clinical guidelines for primary and shared care. Our aim is to provide those involved in developing and implementing practice or locality guidelines with a valuable reference source in a convenient, easy-to-use, working handbook. Due to the continual development and revision of national guidelines, **Guidelines** is updated and published in February, June and October each year.

National and European clinical guidelines, developed by clinicians and sponsored by the relevant independent professional bodies, are summarised and included within **Guidelines**.

Systematic reviews and guidelines published by the National Institute for Health and Clinical Excellence or the Department of Health are highlighted in blue (■). National guidelines produced by independent professional bodies are highlighted in green (■).

There are a number of areas not covered by the NICE and independent professional body guidelines. Consideration also needs to be given to the place of newer interventions omitted from national guidelines that have not been recently updated. For these reasons, summaries of working party guidelines are also included within **Guidelines**. These guidelines are highlighted in yellow (■). They are required to meet the following criteria:

- 1) They must be drawn up by a multidisciplinary group including at least one general practitioner;
- 2) The members of the group should be drawn from several geographical locations;
- 3) The content of the guidelines must be independent of and not influenced by commercial sponsorship of the working party.

Where a guideline is currently under review this is indicated in the title as a dagger (†).

An index of clinical areas covered is located at the end of the publication.

We hope that you find **Guidelines** of help when drawing up your local guidelines, recommendations and policies, and look forward to receiving your feedback as to how it may be further developed to meet your needs.

*Gastrointestinal**Cardiovascular**Respiratory**Central Nervous System**Infection**Endocrine**Obstetrics, Gynaecology
& Urology**Malignant Disease**Nutrition**Musculoskeletal & Joints**Eye, Ear, Nose & Throat**Skin**Immunisation &
Vaccination**General*

New and updated guideline summaries

- List of summaries included for the first time or updated in this edition •

New

- **Antisocial personality disorder: treatment, management and prevention**
 - National Institute for Health and Clinical Excellence
- **Borderline personality disorder: treatment and management**
 - National Institute for Health and Clinical Excellence
- **Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence**
 - National Institute for Health and Clinical Excellence
- **The management of cancer-related breakthrough pain**
 - Recommendations of a task group of the Science Committee of the Association for Palliative Medicine of Great Britain and Ireland
- **Management of acne in primary care**
 - Henderson, Bojar, Bowser, Eady, Mauri-Sole, Mitchell, Page, Papadopoulos, Poyner and Seaton
- **Making medicines safer for children—guidance for the use of unlicensed medicines in paediatric patients**
 - Working Party – Tomlin, Cockerill, Costello, Griffith, Hicks, Sutcliffe, Tuleu, Wong & Wright

Updated

- **Evidence-based guidelines for treating depressive disorders with antidepressants**
 - British Association for Psychopharmacology
- **Aspirin treatment in diabetes**
 - Diabetes UK
- **Preconception care of women with diabetes**
 - Diabetes UK
- **Recommendations for the provision of services in primary care for people with diabetes**
 - Diabetes UK
- **The management of pregnant women with diabetes**
 - Diabetes UK
- **Meningococcal meningitis and septicaemia**
 - Meningitis Research Foundation
- **Management of restless legs syndrome in primary care**
 - RLS:UK

Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease

National Institute for Health and Clinical Excellence

Key priorities for implementation

Primary prevention of CVD

- For the primary prevention of CVD in primary care, a systematic strategy should be used to identify people aged 40–74 who are likely to be at high risk
- People should be prioritised on the basis of an estimate of their CVD risk before a full formal risk assessment. Their CVD risk should be estimated using CVD risk factors already recorded in primary care electronic medical records
- The Framingham 1991 10-year risk equations should be used to assess CVD risk. CVD risk should be calculated as:
 - CVD risk=10-year risk of fatal and non-fatal stroke, + 10-year risk of coronary including transient ischaemic attack heart disease (CHD)^a
- People should be offered information about their absolute risk of CVD and about the absolute benefits and harms of an intervention over a 10-year period. This information should be in a form that:
 - presents individualised risk and benefit scenarios
 - presents the absolute risk of events numerically
 - uses appropriate diagrams and text (See www.npci.org.uk)
- Before offering lipid modification therapy for primary prevention, all other modifiable CVD risk factors should be considered and

their management optimised if possible. Baseline blood tests and clinical assessment should be performed, and comorbidities and secondary causes of dyslipidaemia should be treated. Assessment should include:

- smoking status
 - alcohol consumption
 - blood pressure (see 'Hypertension', NICE clinical guideline 34)
 - body mass index or other measure of obesity (see 'Obesity', NICE clinical guideline 43)
 - fasting total cholesterol, LDL cholesterol, HDL cholesterol and triglycerides (if fasting levels are not already available)
 - fasting blood glucose
 - renal function
 - liver function (transaminases)
 - thyroid-stimulating hormone (TSH) if dyslipidaemia is present
- Statin therapy is recommended as part of the management strategy for the primary prevention of CVD for adults who have a 20% or greater 10-year risk of developing CVD. This level of risk should be estimated using an appropriate risk calculator, or by clinical assessment for people for whom an appropriate risk calculator is not available or appropriate (for example, older people, people with diabetes or people in high-risk ethnic groups)
 - Treatment for the primary prevention of CVD should be initiated with simvastatin 40 mg. If there are potential drug interactions, or simvastatin 40 mg is contraindicated, a lower dose or alternative preparation such as pravastatin may be chosen

^a CHD risk includes the risks of death from CHD, and non-fatal CHD, including silent myocardial infarction, angina and coronary insufficiency (acute coronary syndrome)

Lipid modification therapy

Primary prevention : **Secondary prevention**

Consider drugs for primary and secondary prevention for which there is evidence in clinical trials of a beneficial effect on CVD morbidity and mortality outcomes

Offer 40 mg simvastatin (or drug of similar efficacy and acquisition cost) as part of the management strategy for adults over 40 who have a 20% or greater 10-year risk of developing CVD, based on Framingham 1991 10-year risk equations and clinical judgement

If there are potential drug interactions or 40 mg simvastatin is contraindicated, offer a lower dose of simvastatin or pravastatin

Do not routinely offer:

- higher intensity statins
- anion exchange resins
- fibrates

Do not offer nicotinic acid or the combination of an anion exchange resin, fibrate or a fish oil supplement with a statin

There is no target level for total or LDL cholesterol for primary prevention

Review drug therapy in line with good clinical practice

Repeat lipid profile is not necessary but review management according to clinical judgement and patient preference

Ongoing monitoring

- Measure liver function within 3 months and at 12 months, but not again unless clinically indicated
- If drugs that interfere with statin metabolism are introduced for another illness, consider reducing the statin dose or temporarily or permanently stopping it
- Advise people to seek medical advice if they develop muscle pain, tenderness or weakness
- Do not routinely monitor creatine kinase in people without adverse events, but do measure it in people with muscle symptoms
- Stop statins and seek specialist advice if unexplained peripheral neuropathy develops

If statins are not tolerated for primary prevention, consider:

- fibrates
- anion exchange resins
- ezetimibe*

Offer lipid modification therapy as soon as possible

Offer 40 mg simvastatin (or drug of similar efficacy and acquisition cost) to all adults with clinical evidence of CVD

If there are potential drug interactions or 40 mg simvastatin is contraindicated, offer a lower dose of simvastatin or pravastatin

Consider increasing dose to 80 mg simvastatin or drug of similar efficacy and cost if the total cholesterol does not fall below 4 mmol/l or the LDL cholesterol does not fall below 2 mmol/l. Take into account:

- informed preference
- comorbidities
- other drug therapy
- benefits and risks

Use an 'audit' level of total cholesterol of 5 mmol/l to assess progress in groups with CVD. Recognise that less than half will achieve total cholesterol less than 4 mmol/l or LDL cholesterol less than 2 mmol/l

If statins are not tolerated for secondary prevention, consider:

- fibrates
- nicotinic acid
- anion exchange resins
- ezetimibe*

Offer a higher intensity statin to people with acute coronary syndrome. Do not delay until lipid levels are available. Take into account:

- informed preference
- comorbidities
- other drug therapy
- benefits and risks

Measure fasting lipid levels about 3 months after the start of treatment

* See 'Ezetimibe for the treatment of primary (heterozygous-familial and non-familial) hypercholesterolaemia' (NICE technology appraisal guidance 132)

Secondary prevention of CVD

- For secondary prevention, lipid modification therapy should be offered and should not be delayed by management of modifiable risk factors. Blood tests and clinical assessment should be performed, and comorbidities and secondary causes of dyslipidaemia should be treated. Assessment should include:
 - smoking status
 - alcohol consumption
 - blood pressure (see 'Hypertension', NICE clinical guideline 34)
 - body mass index or other measure of obesity (see 'Obesity', NICE clinical guideline 43)
 - fasting total cholesterol, LDL cholesterol, HDL cholesterol and triglycerides (if fasting levels are not already available)
 - fasting blood glucose
 - renal function
 - liver function (transaminases)
 - thyroid-stimulating hormone (TSH) if dyslipidaemia is present.
- Statin therapy is recommended for adults with clinical evidence of CVD
- People with acute coronary syndrome should be treated with a higher intensity statin. Any decision to offer a higher intensity statin should take into account the patient's informed preference, comorbidities, multiple drug therapy, and the benefits and risks of treatment
- Treatment for the secondary prevention of CVD should be initiated with simvastatin 40 mg. If there are potential drug interactions, or simvastatin 40 mg is contraindicated, a lower dose or alternative preparation such as pravastatin may be chosen

- In people taking statins for secondary prevention, consider increasing to simvastatin 80 mg or a drug of similar efficacy and acquisition cost if a total cholesterol of less than 4 mmol/litre or an LDL cholesterol of less than 2 mmol/litre is not attained. Any decision to offer a higher intensity statin should take into account informed preference, comorbidities, multiple drug therapy, and the benefit and risks of treatment

full guidelines available from...

National Institute for Health and Clinical Excellence, MidCity Place, 71 High Holborn, London WC1V 6NA
 ☎ – 0845 003 7783 (quote reference number N1459 for the quick reference guide) <http://www.nice.org.uk/>

National Institute for Health and Clinical Excellence. Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. Quick Reference Guide. ISBN 1-84629-704-4

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