
## 2013 Cholesterol Guidelines

After thirteen years, the American Heart Association and American College of Cardiology released new guidelines for cholesterol treatment. They were a major departure from the old standards where we treated “certain” cholesterol numbers. Gone are the days of saying “my cholesterol is high because it is over 200.” Now, we are going to lump you into one of four risk groups. I am going to try to summarize these findings because it will affect your treatment.

The first risk group are people with known heart disease: such as history of a stroke, TIA (mini-stroke), or peripheral arterial disease. If you fall into this group we know you have a problem. In the past we would strive for LDL cholesterol of less than 100, but now we will only be worried about the strength of the statin you take. In this group, we will use Lipitor 80mg or Crestor 20 mg daily (high strength statins). The final LDL number you achieve is no longer important.

The second group are people who have an LDL of more than 190. This group is considered to have a genetic or familial hypercholesterolemia. These patients will also be assigned to high strength statins. Again, the end number is not relevant.

The third group are people aged 40- 75 with diabetes. In the past, this group was considered to already have heart disease, but that has changed and a new risk calculator will determine what drug you need. The new calculator will replace the old Framingham score and has been developed to determine your ten year risk of having an event (stroke or heart attack). If you have a risk of 7.5% or more, you will need a high dose statin, if less than 7.5%, you will receive a moderate dose statin. The moderate dose statins will include Pravacol 40 mg, Lipitor 20mg, Crestor 5 mg, Livalo 4 mg, and Zocor 20 mg.

The fourth group are people aged 40-75 with an LDL of 70-189. These people will be assessed by the aforementioned risk calculator. If you have a risk of 7.5% or higher, you will get a moderate dose statin. If you fall below the 7.5% you do not need therapy.

Factors such as family history, LDL>160, elevated cardio CRP (a blood test for inflammation in arteries), ankle brachial index, and coronary calcium scores are left to be assessed every four to six years. They are allowed to be used in cases where the decision to start a statin is not clear. The most important factor to be considered is the coronary calcium score.

Lifestyle guidelines including forty minutes of moderate exercise (brisk walk or jog) four times a week were included. Weight loss was also recommended but the method by which

you lose it is not important. They did push a Mediterranean style diet rich in fish, chicken, nuts, and vegetables.

The notable absences from these guidelines include the removal of Niacin, Zetia, and Welchol as add on therapy. There are also no treatment guidelines for triglycerides or non-HDL cholesterol. The VAP or advanced particle screening (an expensive test that breaks down LDL particle size) that many lipid specialists use was also excluded, as there is no strong data for their use. I think the most uncomfortable thing for everyone is that we will no longer have a target LDL that we need to achieve.

So what does all of this mean for you? Most important, the dinner table discussion of what my lipid numbers are can end. If you are on the drugs, Welchol, Zetia, Vytorin, Liptruzet, or Niacin we need to see if you truly need them. They are costly and they may not be providing any benefit. Last, following your numbers after you start therapy is no longer as important.

There will be changes to these guidelines as other professional groups throw in their opinion but for now we all need to adjust our thinking. I will need to adjust my way of treatment, but will most likely come to some sort of middle ground between the two sets of guidelines. It will be a work in progress that we will go through together. If you want more detailed information go to: cardiosource.org, the website for the American College of Cardiology.