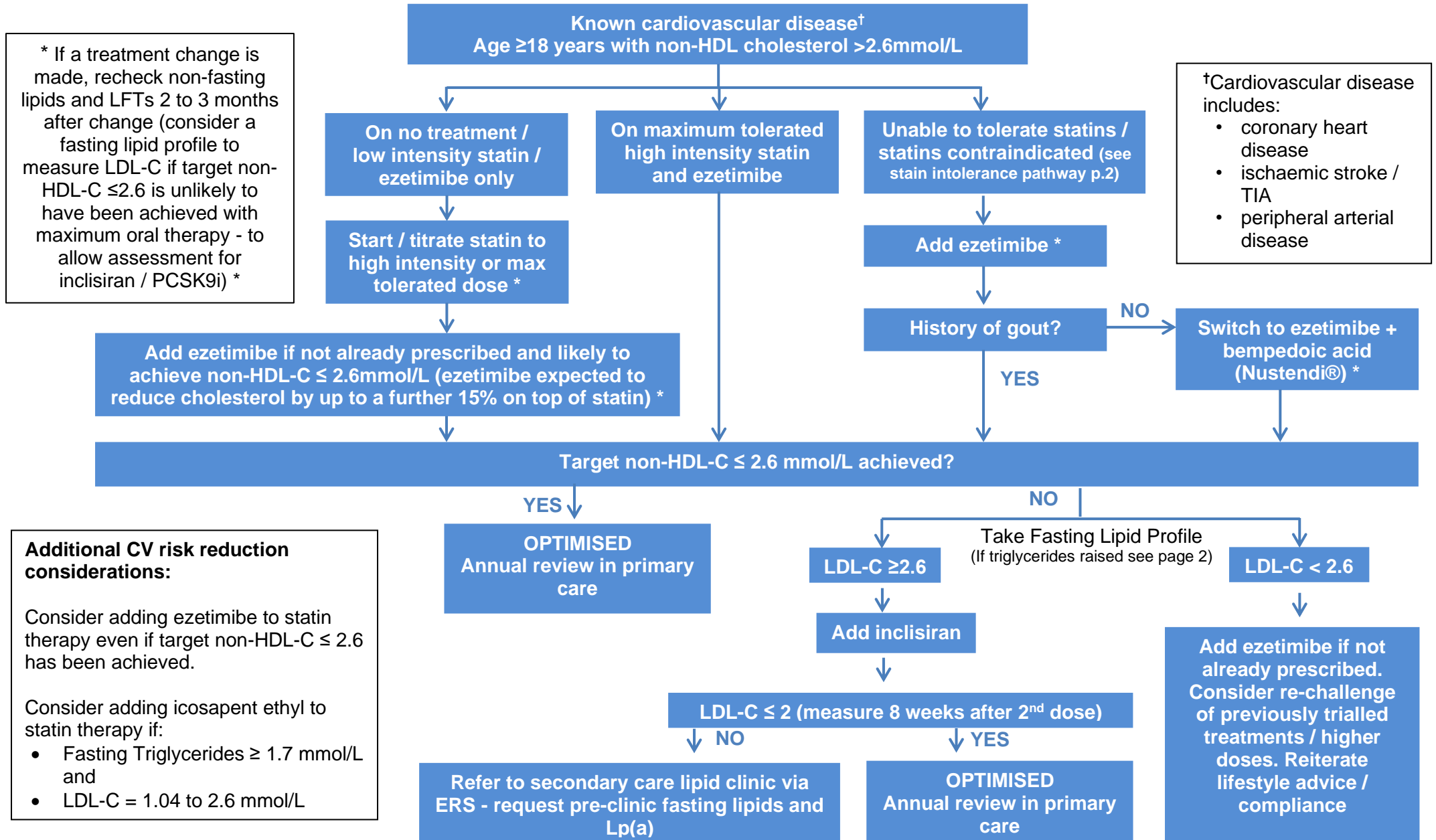


Gloucestershire Secondary Prevention Lipid Management Pathway



Statins

High intensity statins (43 to 55% LDL-C reduction):

- Atorvastatin 20mg-80mg
- Rosuvastatin 10mg-40mg

Start with atorvastatin 80mg (or rosuvastatin 20mg if atorvastatin unsuitable) unless there is a reason to start with a lower dose e.g.:

- Interaction with other drugs
- High risk of adverse effects
- The person would prefer to take a lower dose

If unable to tolerate rosuvastatin:

Start rosuvastatin 5mg once weekly titrating up over 3-4 weeks to twice weekly then alternate days then daily.

If side effects develop then reduce to maximum tolerated dose

See also the [Statin intolerance pathway](#)

Ezetimibe [NICE TA385](#) (further 10 to 15% LDL-C reduction than statin monotherapy)

If target not met on maximum tolerated statin (or statins not tolerated): Prescribe ezetimibe 10mg od. Consider adding ezetimibe to statin therapy even if target achieved.

Bempedoic Acid [NICE TA694](#) (22 to 33% LDL-C reduction with ezetimibe)

Bempedoic acid with ezetimibe is recommended if statins are contraindicated or not tolerated, and ezetimibe alone is insufficient.

Prescribe: Nustendi® (bempedoic acid 180mg + ezetimibe 10mg) 1 tablet od.

Treatment with Nustendi® should be discontinued if hyperuricaemia accompanied with symptoms of gout appear.

Inclisiran [NICE TA733](#) (further 48 to 52% LDL-C reduction than maximum tolerated oral therapy)

See [local information sheet](#) for practical guidance.

Fibrates

If patient already taking a fibrate (fenofibrate / bezafibrate) apply caution in using statin, use lowest dose atorvastatin (risk of myopathy)

PCSK9 inhibitors [NICE TA393](#) / [NICE TA394](#)

Secondary Care Prescribing only.

Icosapent ethyl [NICE TA805](#)

Prescribe: Two 998mg capsules bd (contraindicated in peanut/soya allergy)

Higher risk of bleeding in patients taking concomitant antithrombotics.

Before offering or reviewing treatment:

Consider patient preferences, comorbidities, polypharmacy, general frailty and life expectancy.

Also consider principles of shared care decision making [HERE](#).

Ensure that modifiable [risk factors](#) other than cholesterol are also addressed.

Chronic Kidney Disease:

Atorvastatin: No dose reduction required

Rosuvastatin: If eGFR 30-59 mL/min/1.73m², max dose = 20mg.

If eGFR <30 mL/min/1.73m², max dose = 5-10mg (*Renal Handbook, off label*).

Ezetimibe: No dose reduction required

Bempedoic acid: Limited experience with if eGFR <30 mL/min/1.73m²

Inclisiran: No dose reduction required

(avoid haemodialysis within 72 hours of inclisiran dose)

Icosapent ethyl: No dose reduction required.

Drug Interactions: Patients prescribed warfarin will need regular INR monitoring with statin dose change. Caution when using statins with amiodarone, verapamil, diltiazem, HIV protease inhibitors – use lowest dose atorvastatin.

Annual Review

- Adherence to medication
- [Lifestyle / Diet](#)
- [CVD risk factors](#)
- Annual lipids check
- Check LFTs if statin started in previous 12 months
- Patient Resources – the Heart UK [website](#) contains a number of useful resources for patients

Triglycerides

Triglyceride concentration	Action
>20 mmol/L	Refer to Lipid Clinic for urgent specialist review
10 – 20 mmol/L	Take fasting TG (if not already done) after 5 to 14 days. Refer if TG remains >10mmol. Risk of acute pancreatitis.
4.5 – 9.9 mmol/L	Take fasting TG (if not already done). Optimise CVD risk factors. Refer if TG remains >4.5 and non-HDL-C > 7.5.

CVD Primary Prevention Guideline [click here](#)

Familial Hypercholesterolaemia (FH) Pathway [click here](#)