Clinical Inertia in the Management of Hypercholesterolemia: What Clinicians Need to do

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Hypercholesterolemia is a well-known risk factor for atherosclerotic cardiovascular disease (ASCVD), and the beneficial effect of low-density lipoprotein (LDL) lowering therapy on ASCVD prevention is well established1-3). Although the guidelines for the prevention of ASCVD and the management of dyslipidemia published by the American Heart Association and American College of Cardiology in 20133) defined specific groups of patients who should be prescribed either moderate- or high-intensity statin therapy without aiming for a predefined LDL-cholesterol (LDL-C) goal, we believe that LDL-C goals as recommended by Japanese1) and European2) guidelines remain important because they may be a motivational tool for patients to improve their lifestyle and to adhere to their treatment.

In this issue of the Journal, after analyzing the combined results from Centralized Pan-Regional Surveys on the Undertreatment of Hypercholesterolemia (CEPHEUS) observational studies conducted in 29 countries across five regions, Chiang et al4) report that LDL-C goal attainment in patients prescribed lipid lowering drugs (LLDs) is suboptimal worldwide, particularly in patients at a higher cardiovascular risk. They reported that the presence of diabetes mellitus, hypertension, or history of ASCVD was associated with a significant increase in the proportion of patients attaining their recommended LDL-C level. In contrast, current smokers and individuals with metabolic syndrome or a family history of early-onset CHD were less likely to attain their recommended LDL-C level than those without such ASCVD risk factors.

These results suggest that we clinicians need to give more attention to the patients’ lifestyle and body size.

In addition, the likelihood of attaining the LDL-C goal was greater in patients who had been given a LDL-C goal by their physician than in those who were not. Similarly, those patients who were satisfied with their treatment were more likely to attain their LDL-C goal than those who were not. These important findings indicate that more efforts from clinicians are required to give information with regards to not only the treatment goal but also what the patients want to know, e.g., question like “Have I attained my recommended cholesterol level? If not, what should I do?” (Fig. 1)

Conversely, the observation that familial hypercholesterolemia (FH) was not associated with a significant reduction in the prevalence of LDL-C goal attainment might mislead readers concerned about the management of FH. Generally, despite the use of the highest doses of potent statins, many subjects with FH do not achieve the LDL-C target using only monotherapy5). In the present study, since almost all (90.3%) patients had been prescribed statin monotherapy, we suspect the diagnosis of FH might be not accurate.

Furthermore, the authors stated that the highest likelihood of LDL-C goal attainment was observed in a rosuvastatin treatment group, and they concluded that, in particular, the most effective statins are used and up-titrated as recommended by the guidelines. Although we agree that this finding is a clinically important issue to address, we have to consider that the CEPHEUS studies were funded by AstraZeneca.

In summary, despite these limitations, Chiang et al provided a useful and clear message to clinicians worldwide that there is much space for improvements in patient as well as physician education.

Disclosures

The authors declare that there are no conflicts of interest.
Your LDL-cholesterol level is lowering, but you haven't attained your recommended cholesterol level, i.e., less than 120 mg/dL. You need to undergo additive therapy and should change your lifestyle including smoking.

Fig. 1. Do you give your patients the information that they need to know? Are your patients satisfied with their treatment?

References