

Mayo Clinic challenges some recommendations in updated cholesterol treatment guideline

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A Mayo Clinic task force challenges some recommendations in the updated guideline for cholesterol treatment unveiled by the American College of Cardiology (ACC) and American Heart Association (AHA) in 2013. The task force concludes, based on current evidence, that not all patients encouraged to take cholesterol-lowering medications, such as statins, may benefit from them and that the guideline missed some important conditions that might benefit from medication.

Furthermore, the task force believes an emphasis needs to be placed on an individualized treatment approach with each patient and exercising shared decision-making.

Recommendations of the task force, made up of Mayo Clinic experts in cardiology, endocrinology and preventive medicine, with no conflicts of interest or links to the drug industry, will be published Aug. 14 in *Mayo Clinic Proceedings*. An editorial will accompany the paper. Mayo Clinic physicians are adopting the task force's guideline.

"The ACC/AHA cholesterol guideline was last updated in 2001, so it needed to be updated. We agree with many points of the guideline, but there are some key areas where we do not completely agree or we wanted to expand and provide more guidance," says Francisco Lopez-Jimenez, M.D., task force chairman and director of preventive cardiology at Mayo Clinic in Rochester, Minnesota.

Mayo's cholesterol treatment recommendations challenge some core ACC/AHA recommendations, and go further in-depth in some areas. For example:

* The ACC/AHA cholesterol treatment guideline recommends prescribing the strongest statins at high doses to most men older than 65, even those with no history of heart disease, or any major risk factor for heart attacks, and with normal cholesterol levels. Men this age will be classified as high risk only on the basis of age. The Mayo task force found no evidence from clinical trials to recommend treating people only on the basis of age in the absence of risk factors, high cholesterol or inflammation.

* The ACC/AHA cholesterol treatment guideline recommends cholesterol-lowering medication as a primary preventive measure against [cardiovascular disease](#), and encourages health care providers to simultaneously emphasize the importance of healthy lifestyle habits. The Mayo task force encourages lifestyle changes—such as exercise and dietary changes—first, followed by re-evaluating risk in three to six months before prescribing statins, especially in motivated patients and with borderline high risk.

* The ACC/AHA cholesterol treatment guideline recommends statins for all people with diabetes mellitus who are 40 years or older. The Mayo task force debunks the concept that all diabetics have the same risk as people with history of heart attacks. The Mayo task force does not recommend in favor of or against the use of statins in patients with diabetes in whom the risk for heart attacks or stroke is low based on the calculator proposed by the ACC/AHA.

In addition, Mayo's task force recommends statins to patients with some conditions that the ACC/AHA guideline did not specifically address, such as patients who have rheumatoid arthritis, recipients of a kidney or

heart transplant or those infected with the AIDS virus. These patients are known to have an increased risk of heart attack, Dr. Lopez-Jimenez says.

Second Mayo Clinic task force examined cardiovascular risk assessment guideline

A second Mayo Clinic task force provided a perspective on the new ACC/AHA guideline for assessing cardiovascular risk in patients who do not have heart disease, also released in 2013. The panel recognizes the value of several new features in the guideline, such as specific risk equations for African-Americans, equations to calculate both 10-year and 30-year lifetime risk, inclusion of stroke as an adverse cardiovascular event, and emphasis on shared decision-making.

These recommendations also are published in a second paper Aug. 14 in *Mayo Clinic Proceedings*.

But there are areas where Mayo's risk assessment task force recommended adaptation of the ACC/AHA's recommendations. For example, the ACC/AHA guideline suggests using family history only when a "risk-based treatment decision is uncertain," says Iftikhar Kullo, M.D., Mayo Clinic cardiologist and chair of the risk assessment task force.

"We recommend that family history should be obtained at the time of estimating cardiovascular risk using the new equations," Dr. Kullo says. "Many studies have shown family history to be an independent predictor of cardiovascular risk. Obtaining family history may also help to identify additional individuals in a family who may be at risk."

Mayo's [task force](#) highlights caveats in the use of ankle-brachial index and C-reactive protein for cardiovascular risk assessment—two tests

recommended by the ACC/AHA guideline—and recommends that the following additional tests could be considered to refine estimates of cardiovascular risk:

- * An ultrasound test of the carotid (neck) arteries to measure thickness of the lining of the arteries, as well look for presence of plaque.
- * A noninvasive test (aortic pulse wave velocity) to measure stiffness in the arteries.
- * A blood test to measure lipoprotein(a), a type of LDL (or "bad") cholesterol. Lp (a) level is determined by genes, and high levels are associated with increased [cardiovascular risk](#).

Both Mayo Clinic task forces also emphasized the importance of individualized care and using shared decision-making tools with patients to decide on treatment and determining heart disease risk. "We encourage an individualized approach, particularly when the evidence is inconclusive to a patient's particular situation," Dr. Lopez-Jimenez says. "In addition, we want to find a treatment—whether it's lifestyle changes or perhaps statins—the patient will follow through with because that is what will help make a difference in cardiovascular prevention."

Provided by Mayo Clinic

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