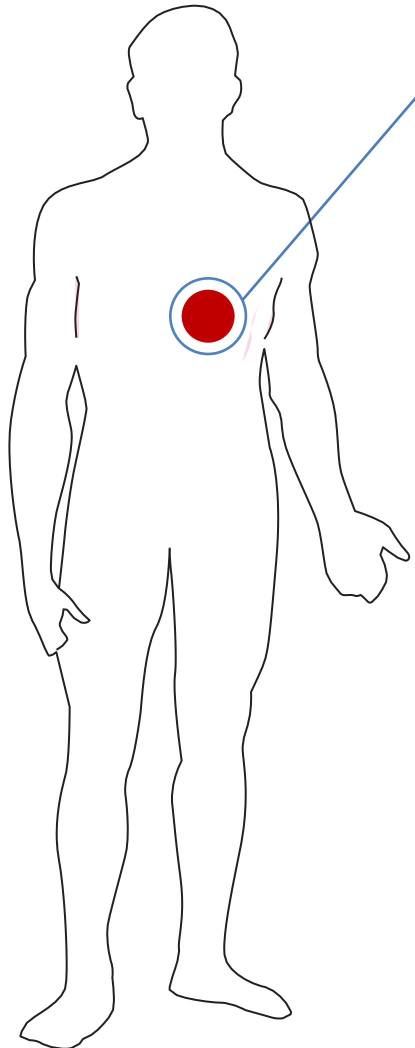
DIABETES – CARDIOVASCULAR RISK (2)

The North West London health and care partnership



LIPIDS

PRIMARY PREVENTION IN TYPE 1 DIABETES:

Consider statin treatment for the primary prevention of CVD in all adults with Type 1 Diabetes
Offer statin treatment for the primary prevention of CVD to adults with Type 1 Diabetes who:

- are older than 40 years **or**
- have had Diabetes for more than 10 years **or**
- have established nephropathy **or**
- have other CVD risk factors.

PRIMARY PREVENTION IN TYPE 2 DIABETES:

Offer atorvastatin 20 mg for the primary prevention of CVD to people with Type 2 Diabetes who have a 10% or greater 10-year risk of developing CVD. Estimate the level of risk using the **QRISK2** assessment tool.

PEOPLE WITH CKD

Increase the dose if a greater than 40% reduction in non-HDL cholesterol is not achieved and eGFR is 30 ml/min/1.73 m^2 or more. Agree the use of higher doses with a renal specialist if eGFR is less than 30 ml/min/1.73 m^2

EXCEPTION - WOMEN OF CHILD-BEARING POTENTIAL/PREGNANT

TREATMENT TARGETS

Dietary interventions alone only reduce cholesterol by <10%. To reach targets, often drug therapy will be required.
The initial target is to achieve a total cholesterol of <4.0 mmol/l and an LDL of <2.0 mmol/l. Statins are first line drugs for this indication. In accordance with NICE guidelines **Atorvastatin 20mg** is first choice.
Increase from atorvastatin 20mg/day to **atorvastatin ≥40mg/day** unless total cholesterol level is below 4.0mmol/l or LDL cholesterol level is below 2.0mmol/l. Also consider intensifying to atorvastatin ≥40mg/day if there is existing or newly diagnosed CV disease, or increased albumin excretion rate.
If Atorvastatin is not tolerated consider using **Rosuvastatin**.

Monitor LFTs 6 weeks post initiation of statin. If normal check annually

In females who are planning a pregnancy or who are pregnant these drugs should be withheld until breast feeding has ceased

Ezetimibe should be prescribed as per NICE's guidance.(TA 385)
If a greater than 40% reduction in non-HDL cholesterol is not achieved:

- discuss adherence and timing of dose
- optimise adherence to diet and lifestyle measures
- consider increasing the dose if started on less than atorvastatin 80 mg and the person is judged to be at higher risk because of comorbidities, risk score or using clinical judgement

It is important to note that the target triglyceride level is a fasting target, so an individual with a non-fasting result >2.3 mmol/l should be invited back to have a fasting triglyceride estimation. HDL and triglyceride interventions include lifestyle (predominantly weight loss and exercise) and drug therapies. The drug of choice is a fibrate, usually **Fenofibrate 160mg**. If using a combination lipid lowering regimen, monitoring of ALT and CK is appropriate.

Monitor lipids 6 weekly until targets have been achieved, and annually thereafter.

Remember that, if the patient does not achieve target despite greatest efforts by the multidisciplinary team, any improvement towards the target is better than the patient's baseline.

Fibrates should not be commenced if eGFR is <45. They should be discontinued with deterioration of renal function.

ANTI-PLATELET AGENTS

Aspirin 75 mg daily is indicated for all people with Diabetes who have any form of cardiovascular disease. In those who are also hypertensive the blood pressure should be controlled to 145/90 or below before commencement of aspirin. If aspirin is not tolerated or is contraindicated, clopidogrel 75 mg daily should be considered.

Lifestyle advice is integral to the management of Diabetes and should be reinforced at every available opportunity.