Mastering cholesterol to optimise CVD prevention webinar series

Statins: Friend or foe? (11 May 2023)

Q&A with Tawfiq Choudhury (TC) and Rocco Hadland (RH)

Question 1

Should statins be initiated in patients over the age of 84 years?

TC: In that age group, and in fact in all of medicine, we individually assess the patient and that is very important. All over 84s are not the same. If you have an 84 year old cardiovascular patient with a history of diabetes, with hypertension and was high risk of cardiovascular disease but is otherwise quite fit and healthy, there's no reason to deprive them of a statin. But if you have an 84 year old who is, maybe, housebound, with severe frailty and has multiple other co-morbidities, then that might be a different issue. In elderly patients, one of the key things to bear in mind is that we're trying to get an improvement in healthy lifespan, and reduce a disability lifespan. So that's a shared decision which has to be made, but the key message is that patients, irrespective of age, if they are high risk, then statins certainly need to be considered in this group.

RH: It's what is important for the patient, absolutely. Don't assume that the patient does not want to take the medication. Certainly, when I see patients in deprescribing clinics, they say 'well this tablet is very important; the doctor said I should take these', so yes; have that discussion with your patient. Don't assume that it is the right thing to do to stop the medication.

Question 2

If you have a QRISK of <10%, but a cholesterol of 8.1, would you start a statin?

RH: QRISK very often underestimates the risk for patients with Familial Hypercholesterolemia (FH), so certainly it might be worth considering that as a possible pathology. I have had patients where they were right on the cusp of the QRISK and we have actually said 'let's try the statin'. And they appreciate that it's not quite indicated, however, there's some evidence now that says a lower QRISK should be considered. I think as long as you have that discussion with the patient, and support them with their lifestyle advice, but what's certainly worth thinking about is FH. Don't just assume that because the QRIK is low, there's not something else going on.

TC: Once FH is being considered and, even if that's not the case, a QRISK is just a score. What we need to bear in mind is the lifetime exposure to high cholesterol. Someone who's young and has a high cholesterol; the QRISK score might not reflect their risk. I think there will be a change in thinking about just using this risk threshold to prescribe statins and anyone below 10% is not going to get one; I think that's going to change. It's going to be about shared decision making; about discussion with the patient, explaining the risk and if they're keen to take statins then they should be prescribed, as what you want to reduce is the lifetime exposure to high cholesterol.

Question 3

Some clinicians in primary care sometimes mark lipid levels as 'satisfactory'. When you interrogate, you can see that the desired effect has not been achieved. Any ideas on how to address this? We have some patients who say to us, 'oh, I was told previously that I was ok'. How would you manage that?

RH: It's the same principle as you giving someone a blood pressure tablet. If you start on a low dose and your blood pressure is still very high, we are not achieving our therapeutic goal. So I would challenge 'satisfactory' levels that are not satisfactory. We are doing our patients a disservice by calling those levels satisfactory and if they are not achieving the target, we should be doing something about it and reduce the risk of patients needing to be seen in secondary care in the first place. But that's the aim; to reduce the risk of cardiovascular disease, so I think that is wrong and we should do something about that.

Question 4

If the patient has aches and pains and the statin is suspected as the cause, do I stop the statin and ask them to continue, whilst I check CK, and how quickly will stopping taking a statin cause any rise in CK to fall?

TC: For that I would refer you to the Statin Intolerance Pathway, which is a very nice document which has an algorithmic approach. The assessment says to assess the severity of the symptoms, measure the CK and then, depending on the rise in CK, if it's 4x above the upper limit of normal, then consider discontinuing the statin. So I wouldn't just discontinue the statin straight away and then do all the other measurements; I would do a thorough assessment, measure the CK, and then, based on that, according to the algorithm in the Statin Intolerance Pathway, take the appropriate measures.

RH: Yes I agree with that. The flip side in primary care is that we don't always have up-to-date CK levels, so sometimes you have to be a little bit more pragmatics and, depending on the symptomology the patient presents with, sometimes it might be wort stopping it for a few days, just to rule out, if you don't have the benefits of the CK. And then restarting it.

Question 5

Should low intensity statins and older statins really now still be initiated and continued, or should we focus on high intensity? And should we consider switching people already prescribed low intensity, to statins such as atorvastatin and rosuvastatin instead?

RH: Yes. I think so. We are potentially wasting NHS resources by giving patients medication that is not fit for purpose. And we know that the low dose, high intensity statins have much better clinical outcomes and we know they are safe medications. Again, I think we are doing our patients a disservice. Some patients will prefer not to change, which is ok, however I do think we should at least offer them and say that statins have evolved over the last couple of years and we now have the benefit of much better statins that we can use at much lower doses that will have a better protective effect and will reduce the risk of cardiovascular disease. So certainly I don't think they should be

initiated, but certain patients that are on them should be offered the choice to go onto a more modern statin.

TC: I agree. The guidance it pretty clear. Primary prevention start off with atorvastatin 20mg; secondary prevention atorvastatin 80mg. Unless of course they have CKD; that's a different issue. But if they're on simvastatin 10mg then that's a bit worrying and that needs to be addressed.

Question 6
Is there any evidence that statins reduce the progression or onset of vascular dementia?

TC: We don't have any strong evidence on that, but as I mentioned [in my presentation] there are two trials that will be looking at dementia in the age group with statins, so they might shed more light on this.

Question 7
Are you aware of any data search tools which might be available to use against the new QOF indicators?

RH: There are searches available via the Innovation Agency (IA) [referring to https://uclpartners.com/our-priorities/cardiovascular/proactive-care/search-and-risk-stratification-tools/] and if practices have access to Ardens searches, there will certainly be a search in there that will look at secondary prevention with high LDL and non-HDL levels.

IA addendum: NHS Digital tool also available: https://digital.nhs.uk/services/lipid-management-searches

Question 8
If a female patient falls pregnant on a statin, what is the risk to the developing baby and what action should be taken?

RH: It depends on the statin; I would need to look that up. I would look into things such as foetal exposure, lactation; all of that.

IA addendum: NHS Advice and Guidance service: https://www.england.nhs.uk/elective-care-transformation/best-practice-solutions/advice-and-guidance/
"Advice and Guidance (A&G) services are a key part of the National Elective Care Recovery and Transformation Programme's work. A&G provides primary care with continued access to specialist clinical advice, enabling a patient's care to be managed in the most appropriate setting, strengthening shared decision making and avoiding unnecessary outpatient activity."

Question 9

Would you consider the maximum dose of a high intensity statin in primary prevention?

RH: I've never seen that in primary care for primary prevention. I've seen doses go up to 40mg and adding ezetimibe, but I would refer to someone like Tawfiq [Choudhury] and pick their brain about that. But certainly, if you're not controlling on atorvastatin 20mg or 40mg, or possibly 60mg, then it may be worth looking into adding another agent. It's just the risk of side effects with atorvastatin 80mg, potentially.

TC: Yes, I agree with that. There is data that adding ezetimibe might well result in a better LDL reduction than doubling the dose. So if you're at atorvastatin 40mg, I guess adding ezetimibe makes perfect sense. But I think that the main aim is to get that cholesterol level down. And whatever needs to be done, needs to be done. So if they're on atorvastatin 40mg and you add on ezetimibe, then that's a very reasonable option, but if you were to double it to 80mg and get that cholesterol reduction, as long as we achieve that aim and the patient is tolerating it well I can't see there being any major issues.

RH: I find it is very powerful bringing to patients the visual aspect of showing them the graph of their cholesterol levels, and it going down. So I would wonder about atorvastatin 80mg in primary prevention…I'd wonder about non-adherence. Or something else going on.

Question 10

How long should a patient remain on atorvastatin 80mg after a cardiac event?

TC: It's going to be long term. That's what I would say to them; long term. Because the trials that I mentioned [in my presentation]; treating with statins for 5 years, a lot of the data is anywhere between 3 to 5 year mark with the follow up, so I don't think we have any set end point when you start atorvastatin 80mg. So I usually say to my patients 'you've had a cardiac event, just carry on'. And they are usually ok with it; most of them.

RH: Some patients are reluctant and find that swallowing the tablet, specifically, that is a big barrier. Atorvastatin is quite a big tablet, but we tend to keep them on. Sometimes we reduce them down because of the side effects, but generally the advice is to carry on as long as you can.

Question 11

Can I stop checking LFTs altogether for people whose baseline LFT was normal, provided that they have no change in their health?

RH: I would feel happy with annual LFTs. Some people might argue that's a bit overkill, but I think that annual LFTs are possibly what most clinicians do in primary care.

TC: First of all, I don't get to see many of these patients, for obvious reasons and they end up in primary care. Even my secondary prevention patients. But when I look at the guideline, it says check it at baseline, three months, one year and then after that it doesn't need to be done again unless the

patient develops new onset jaundice or any other issue where you are expecting liver disease. So for the first year, yes, I would do that, but beyond that I wouldn't probably do that, unless clinically indicated. But having said that, I don't see many of these patients and you see a lot more of these patients in the community.

Question 12

Regarding the addition of bempedoic acid, when we are looking at uric levels, what reference range are we going with; EMIS reference range goes up to 600, but from a gout point of view we are looking at levels below 300 or 360. I had a patient recently with uric levels of 460 and no history of gout. Would this be ok to initiate bempedoic acid?

RH: It's a tricky one. I would probably err on the side of caution with a urate of 400 because it's not officially classed as controlled then. My gut feeling, and this is just me thinking out loud, is that I would probably err on the side of caution and maybe wait until the gout; the uric acid, is a little bit lower than that.

Question 13

What would you advise with a patient with FH who needs to restart a statin after having a baby but wants to breastfeed?

RH: I would have to look into the lactation information and exposure in the breast milk. I don't know without looking and knowing which statin it is, and the advice [surrounding it].

TC: My colleague in our lipid service will be doing a presentation on FH [during webinar 4 of this 5 webinar series], so should be able to address all of these specific points then.

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Question 14

If a patient complains about potential side effects due to a statin, how long would you suspend that statin before trying an alternative?

RH: It depends on the side effect and the severity of the side effect I suppose. We talked about the muscle side effects so it all depends on what exactly the side effects are. Is it acceptable for the patient? Is it a headache, is it a stomach upset, is it muscle aches and pains, is it hair loss, which I have had a few times? If it's hair loss then then you would stop it immediately and try something different. So it all depends on the severity of the side effect and what type of side effect.

TC: If you look at the Statin Intolerance Pathway, if the patient's got symptoms which are intolerable and the CK for example is more than 4s the upper limit of normal, then the recommendation I think is to stop it for 4-6 weeks and then reassess the symptoms at that time.

Final thoughts from speakers

RH: One final thought is to ask your patients about concerns they might have about medication, and this would apply to statins and other medications. Patients will not take their medications because they are worried about side effects or worried about something they've read in the news. So I think that if you ask that open ended question; 'do you have any concerns?' Certainly I've seen patients that come through that have had interventions done, whether it be CABGs or PCIs and they've stopped their statins because they had concerns about the medication and I think that we need to be aware of this and support them with the right decision. So ask about concerns and have the opportunity to address those and reassure them.