SEMERGENRED

Comunidad Valenciana

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Acreditación solicitada:

EVES
ESCOLA VALENCIANA D'ESTUDIS DE LA SALUT

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SEMERGEN
Sociedad Española de Médicos de Atención Primaria
AP
Comunidad Valenciana

Con el patrocinio de:

MSD
INVENTING FOR LIFE

Declaración de conflicto de intereses

en relación con la temática de la presentación

Ponente

- *Ferrer, Amgen, Sanofi, Servier, Astra-Zeneca, Boehringer Ingelheim – Lilly, Janssen, Mundifarma MSD; NovoNordisk, Bayer, Daiichi Sankyo, Pfizer-BMS, Novartis, Rovi, Vifor, Servier*

Advisor board

- *MSD, Amgen, NovoNordisk, Astra-Zeneca, Boehringer Ingelheim – Lilly, Novartis, Vifor, Pzifer, Daicchi, Mundifarma, Bayer.*

Invitación a congresos

- Rovi, Vifor Pharma, Astra, Boehringer Ingelheim, Janssen, MSD, *Boehringer Ingelheim*

***Investigador en ensayos clínicos*:**

- Novartis; Astra, Daiichi Sankyo

Participación remunerada en la presente sesión por MSD

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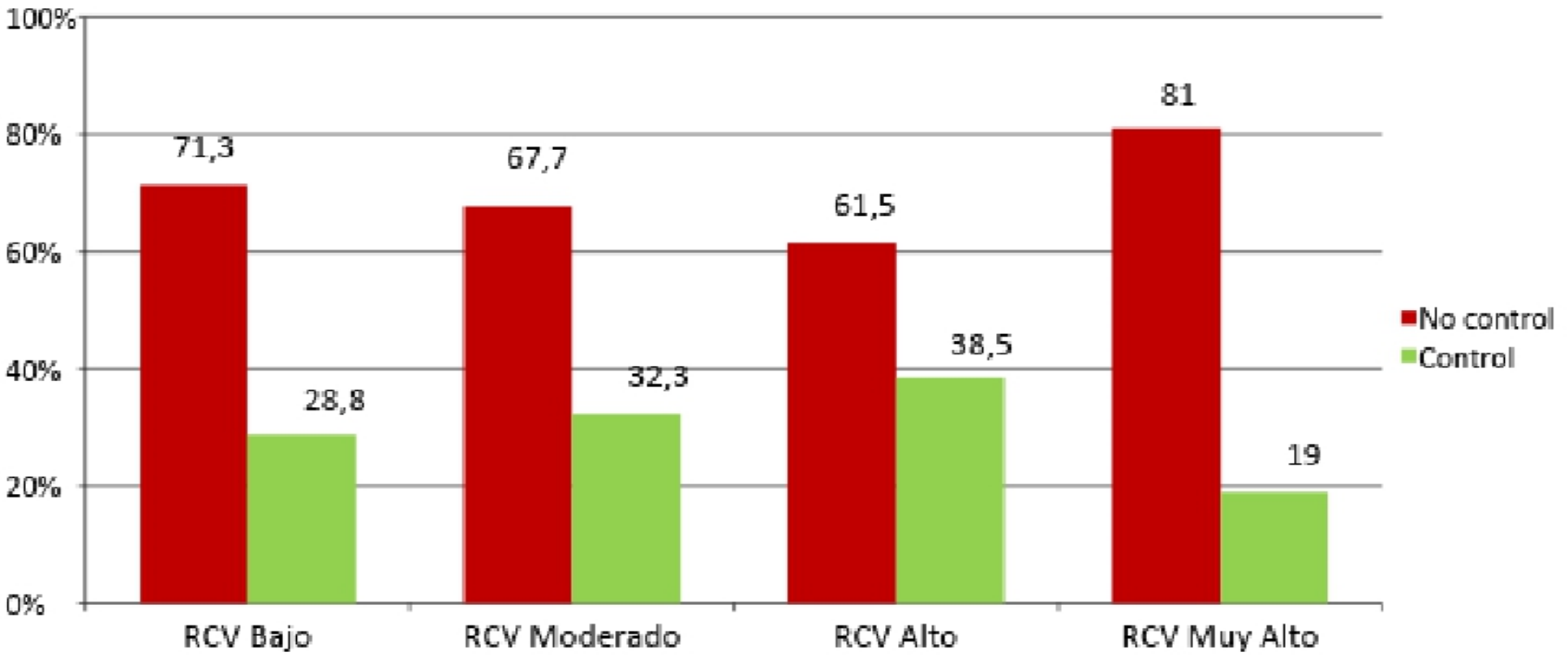
marinaSalud laSalud TU HOSPITAL

Very-high-risk	People with any of the following: Documented ASCVD, either clinical or unequivocal on imaging. Documented ASCVD includes previous ACS (MI or unstable angina), stable angina, coronary revascularisation (PCI, CABG and other arterial revascularization procedures), stroke and TIA, and peripheral arterial disease. Unequivocally documented ASCVD on imaging includes those findings that are known to be predictive of clinical events, such as significant plaque on coronary angiography or CT scan (multivessel coronary disease with two major epicardial arteries having >50% stenosis) or on carotid ultrasound. DM with target organ damage, ≥3 major risk factors or early onset of T1DM of long duration (>20 years). Severe CKD (eGFR <30 mL/min/1.73 m^2). A calculated SCORE ≥10% for 10-year risk of fatal CVD. FH with ASCVD or with another major risk factor.

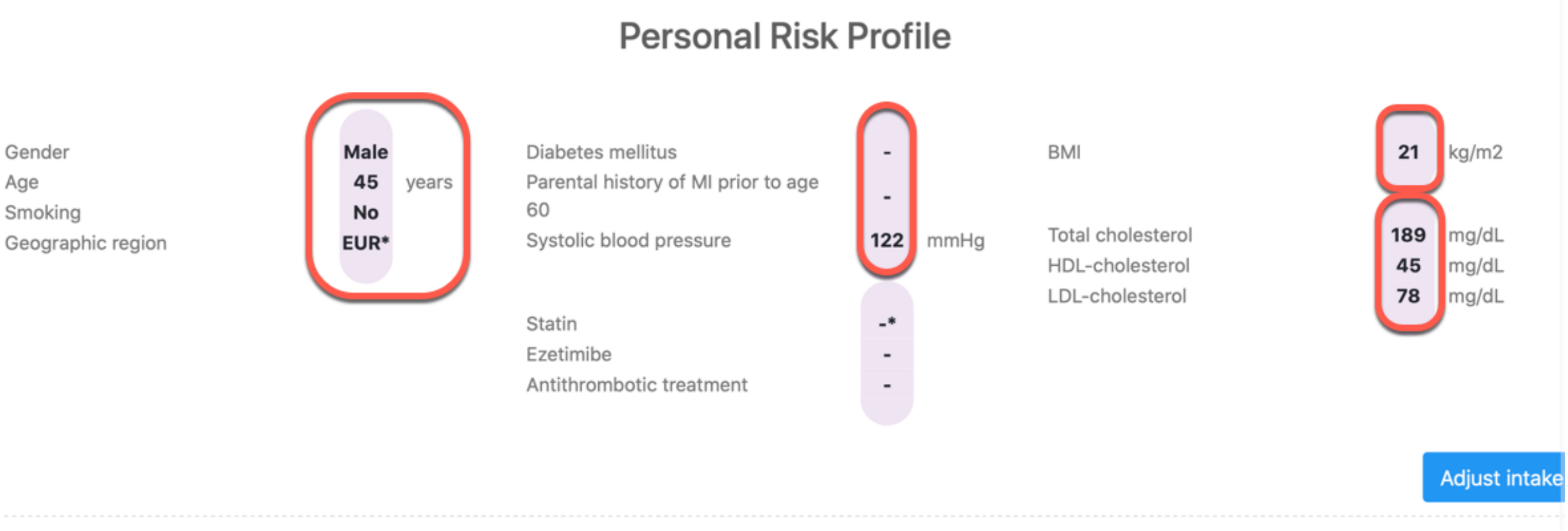
High-risk	People with: Markedly elevated single risk factors, in particular TC >8 mmol/L (>310 mg/dL), LDL-C >4.9 mmol/L (>190 mg/dL), or BP ≥180/110 mmHg. Patients with FH without other major risk factors. Patients with DM without target organ damage*, with DM duration ≥10 years or another additional risk factors. Moderate CKD (eGFR 30–59 mL/min/1.73 m^2). A calculated SCORE ≥5% and <10% for 10-year risk of fatal CVD.
Moderate-risk	Young patients (T1DM <35 years; T2DM <50 years) with DM duration <10 years, without other risk factors. Calculated SCORE ≥1% and <5% for 10-year risk of fatal CVD.
Low-risk	Calculated SCORE <1% for 10-year risk of fatal CVD.

Dislipemia: Grado de control según RCV

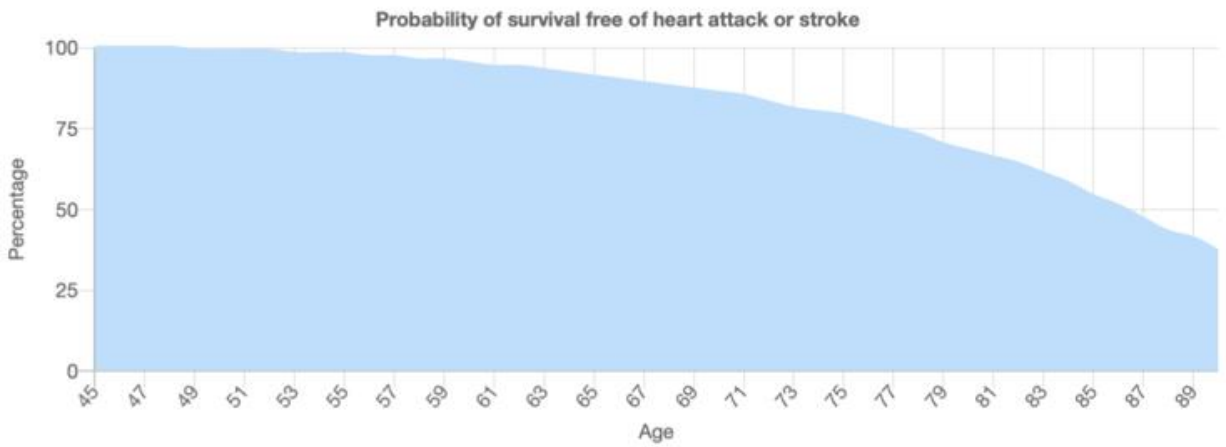


Estudio IBERICAN. Agencia de Investigación. Fundación SEMERGEN

- Paciente joven riesgo moderado/bajo



CVD-free life-years | 10-years risk | Lifetime risk



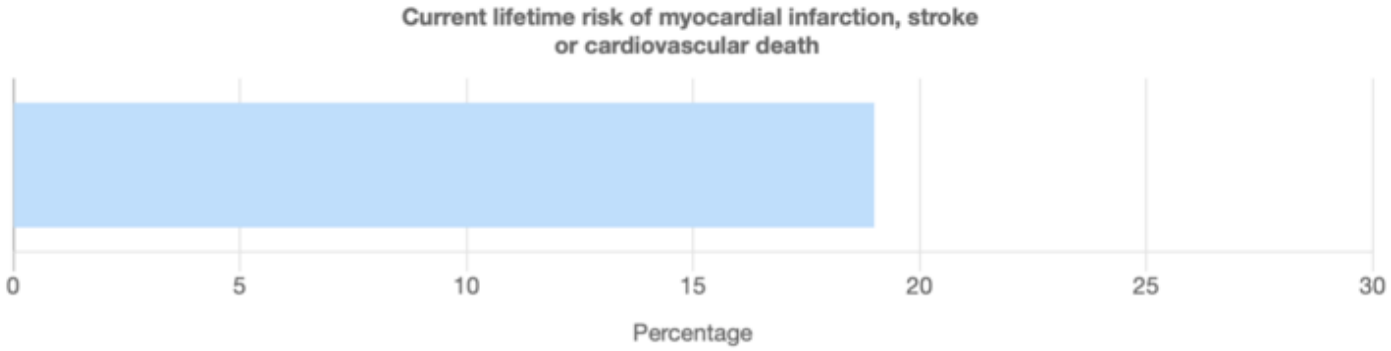
/bajo

45
Age start treatment

86
CVD-free life-expectancy

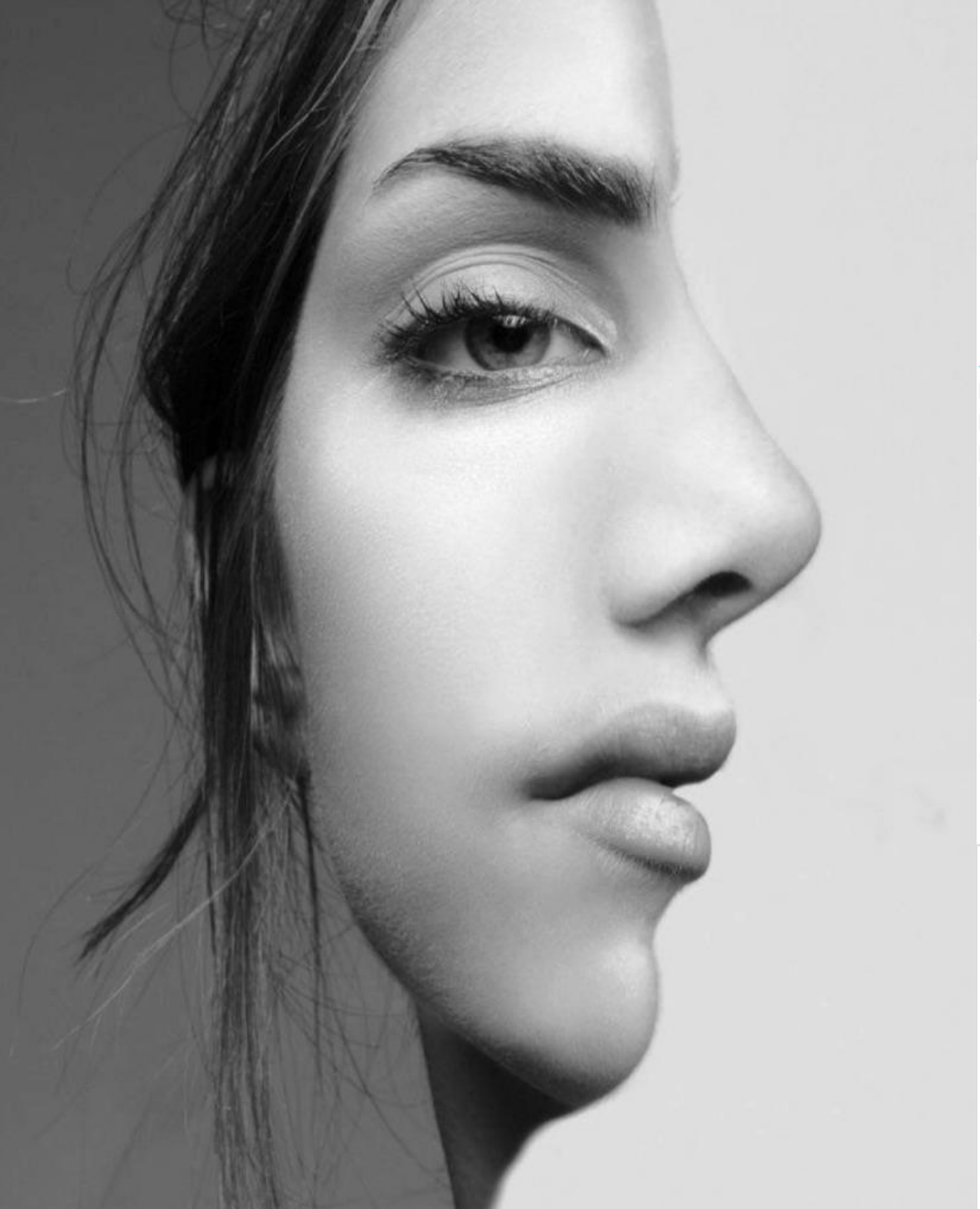
0
CVD-free years gained

CVD-free life-years | 10-years risk | Lifetime risk



19%
Current risk

0%
Reduction with treatment



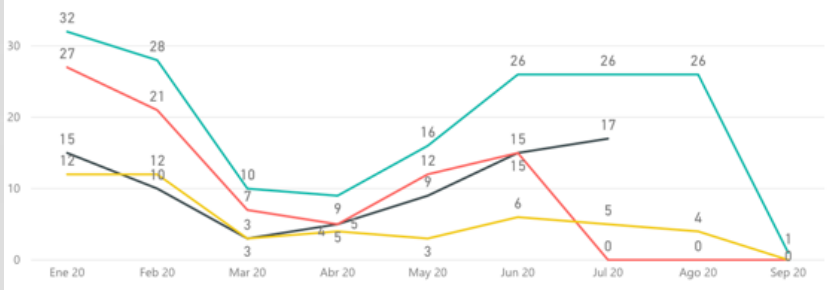
LDL Seguimiento

174
Nº IAM

Zona: Todas | AñoMes: Todas | Año Filtro: Último Año

Estado Salud	Estado Salud Descr.	Población con IAM	Sin control	Sin control en plazo (< 3 meses)	Último LDL > 50
		17	7	7	2
0	Sin Clasificar				
1	Estado de salud sano	8	7	4	1
2	Historia de enfermedad aguda significativa	1	1	1	0
3	Enfermedad crónica menor única	2	2	2	0
4	Enfermedad crónica menor en múltiples sistemas orgánicos				
5	Enfermedad dominante o crónica moderada única	37	19	20	9
6	Enfermedad significativa crónica en múltiples sistemas orgánicos	74	28	37	25
7	Enfermedad dominante crónica en tres o más sistemas orgánicos	27	10	15	10
8	Neoplasias dominantes, metastásicas y complicadas				
Total	**Enfermedad crónica menor en múltiples sistemas orgánicos**	**168**	**74**	**87**	**49**

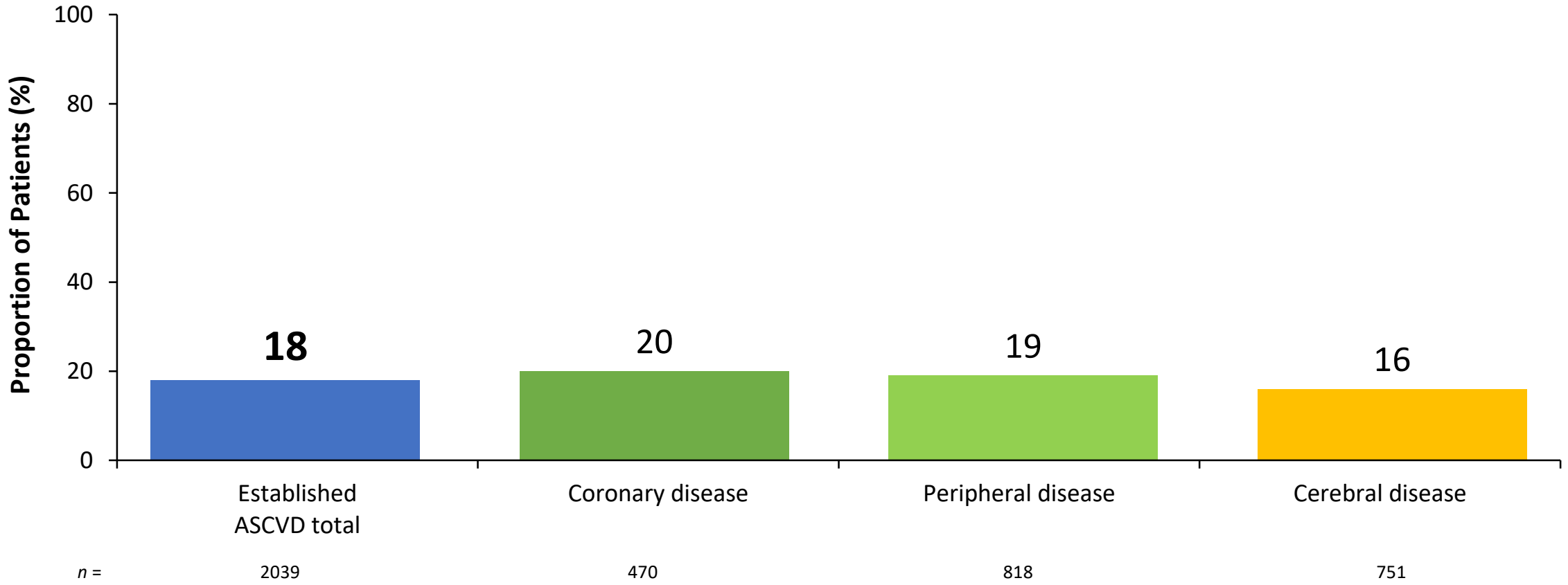
Nº IAM · Sin control · Sin control en plazo (< 3 meses) · Último LDL > 50



Edad	Sexo	NEPI	NRI	Nº IAM	Sin control	Último LDL > 50	Sin control en plaz
46	Masculino	6634014	26577	1	0	1	
68	Masculino	6774193	79334	1	0	1	
85	Masculino	6774813	32554	1	0	1	
81	Masculino	6781114	71427	1	0	1	
89	Masculino	6789694	19441	1	0	1	
81	Masculino	6797869	71427	1	0	1	
75	Femenino	6799410	302002	1	0	1	
68	Femenino	6813469	2576	1	0	1	
74	Masculino	6813720	149431	1	0	1	
70	Masculino	6813753	25254	1	0	1	
54	Masculino	6829576	117786	1	0	1	
66	Femenino	6838832	79241	1	0	1	
85	Femenino	6839841	20228	1	0	1	
74	Masculino	6842505	124658	1	0	1	
76	Masculino	6843413	30022	1	0	1	
63	Masculino	6849146	302748	1	0	1	
60	Masculino	6860718	162259	1	0	1	
80	Masculino	6866998	5878	1	0	1	
78	Masculino	6883651	38151	1	0	1	
80	Masculino	6883813	31537	1	0	1	
44	Masculino	6894200	127002	1	0	1	
67	Masculino	6894258	18338	1	0	1	
66	Masculino	6894726	6594	1	0	1	
85	Masculino	6896518	43350	1	0	1	
56	Femenino	6899795	26913	1	0	1	
65	Masculino	6914510	282165	1	0	1	
64	Masculino	6934026	133703	1	0	1	
12233				**174**	**74**	**49**	

38/174 = 21%

Among Patients with Established ASCVD, 18% Achieved the 2019 ESC/EAS Very-High Risk Goal of LDL-C < 1.4 mmol/L (< 55 mg/dL)



In very high risk patients, 2019 goal attainment was approximately half that of 2016 (18% vs 39%).

ASCVD = atherosclerotic cardiovascular disease; EAS = European Atherosclerosis Society; ESC = European Society of Cardiology; LDL-C = low-density lipoprotein cholesterol.

Ray, KK et al. *Eur J Prev Cardiol*. 2020. Suppl. [in press].

Alcanzar niveles más bajos de C-LDL tras IM está asociado con un menor uso de recursos y costes

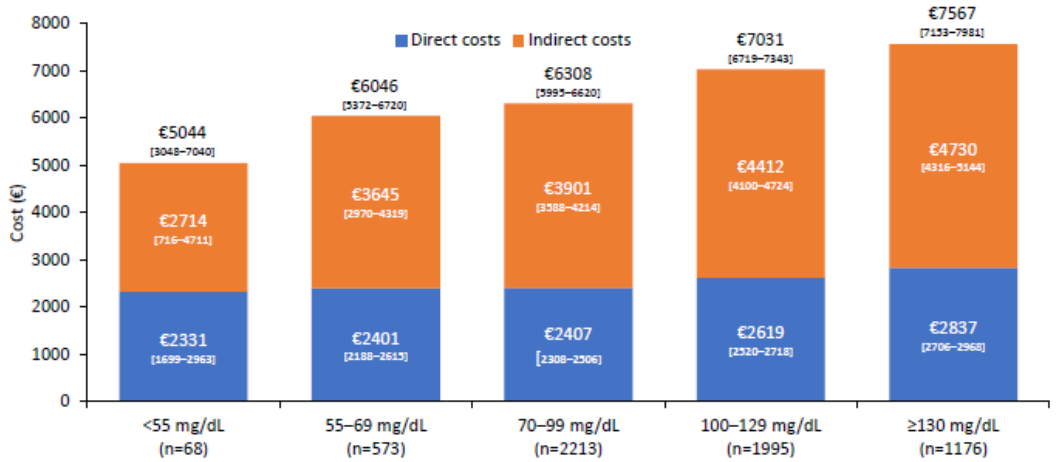
- Sólo el 11% de los pacientes alcanzaron niveles de C-LDL < 70 mg/dL, tal y como recomiendan las guías ESC/EAS 2016 en pacientes de muy alto riesgo. **Sólo un 1% de los pacientes alcanzaron los niveles recomendados de C-LDL (< 55 mg/dL)** en las guías ESC/EAS 2019.
- **El uso de recursos sanitarios y los costes decrecieron con niveles más bajos de C-LDL alcanzados** (fig 2).

Tab 1. Uso de recursos según el nivel de C-LDL alcanzado tras un IM (18 meses)

	Achieved LDL-C, mg/dL					
	<55 (n=68)	55–69 (n=573)	70–99 (n=2213)	100–129 (n=1995)	≥130 (n=1176)	Overall (n=6025)
Primary care visits	27.6 (20.7)	29.9 (27.1)	29.5 (24.9)	29.7 (24.2)	31 (26.1)	29.9 (25.1)
Laboratory requests	4.0 (5.1)	3.4 (3.6)	3.2 (3.2)	3.2 (3.1)	3.7 (1.9)	3.3 (3.0)
Radiology requests	0.7 (1.0)	0.9 (1.3)	0.9 (1.2)	0.9 (1.1)	0.9 (1.2)	0.9 (1.2)
Other tests	1.3 (0.5)	1.5 (0.6)	1.6 (0.6)	1.7 (0.7)	1.7 (0.8)	1.6 (0.7)
Specialized visits	2.5 (1.0)	2.8 (1.1)	2.7 (1.1)	3.2 (1.3)	3.2 (1.2)	3.0 (1.2)
Emergency room visits	0.3 (0.5)	0.5 (1.8)	0.5 (0.9)	0.7 (1.2)	0.9 (1.4)	0.6 (1.2)
Days in hospital	0.1 (0.8)	0.8 (2.4)	1.1 (3.4)	1.7 (4.3)	2.0 (4.7)	1.4 (3.9)
Days of sick leave	34.6 (61.5)	35.7 (69.3)	41.6 (69.6)	41.1 (79.7)	41.3 (78.6)	40.8 (74.8)

Data expressed as mean (standard deviation)

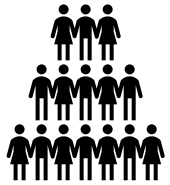
Fig 2:Costes según el nivel de C-LDL alcanzado tras un IM (18 meses)



Data expressed as mean [95% confidence interval]

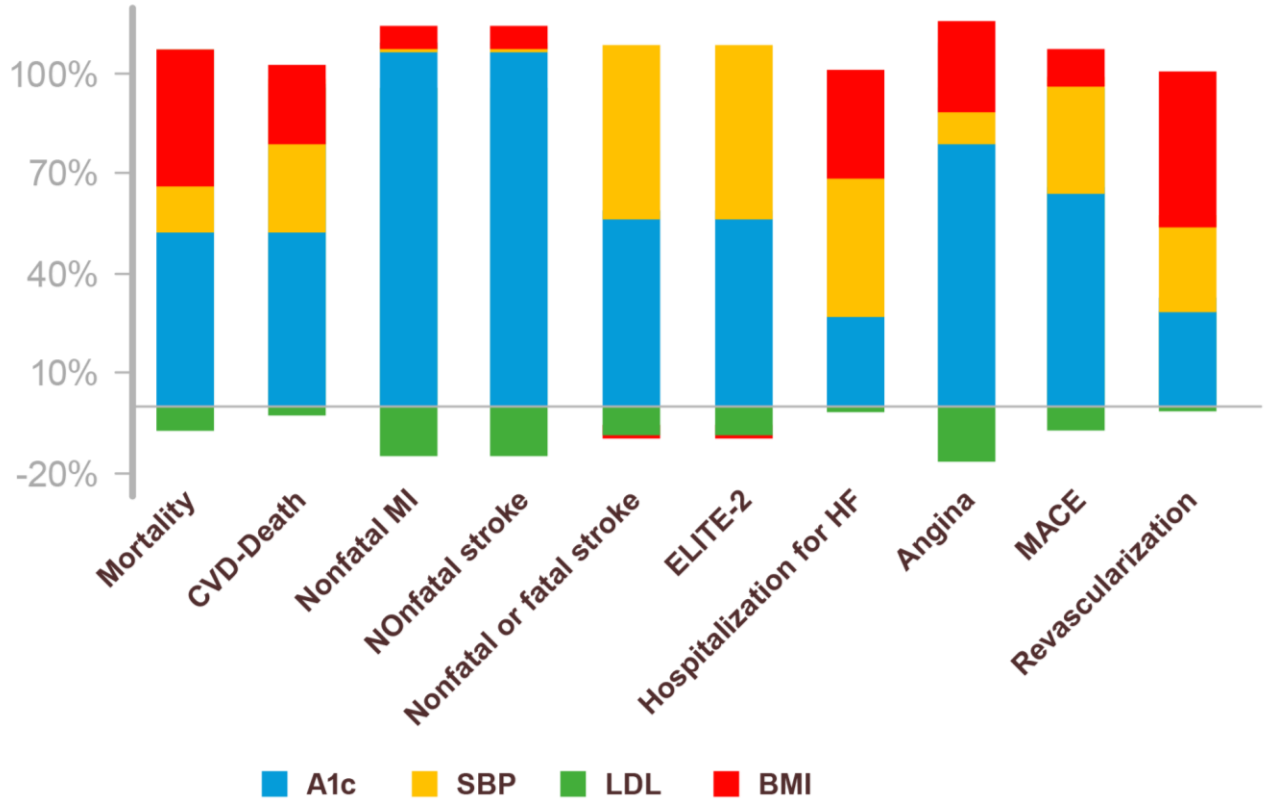
Costs are corrected by Analysis of Covariance based on pairwise comparisons between the estimated marginal averages

Carlos Escobar-Cervantes[1], Ignasi Campos-Tapias[2], Francesc Sorio-Vilela[3], Javier Lozano[2], Doreen Kahangire[3], Antoni Sicras-Mainar[4]
[1]Unidad cardiología, H La Paz; [2]Amgen S.A.; [3]Amgen (Europe) GmbH; [4]Atrys Health



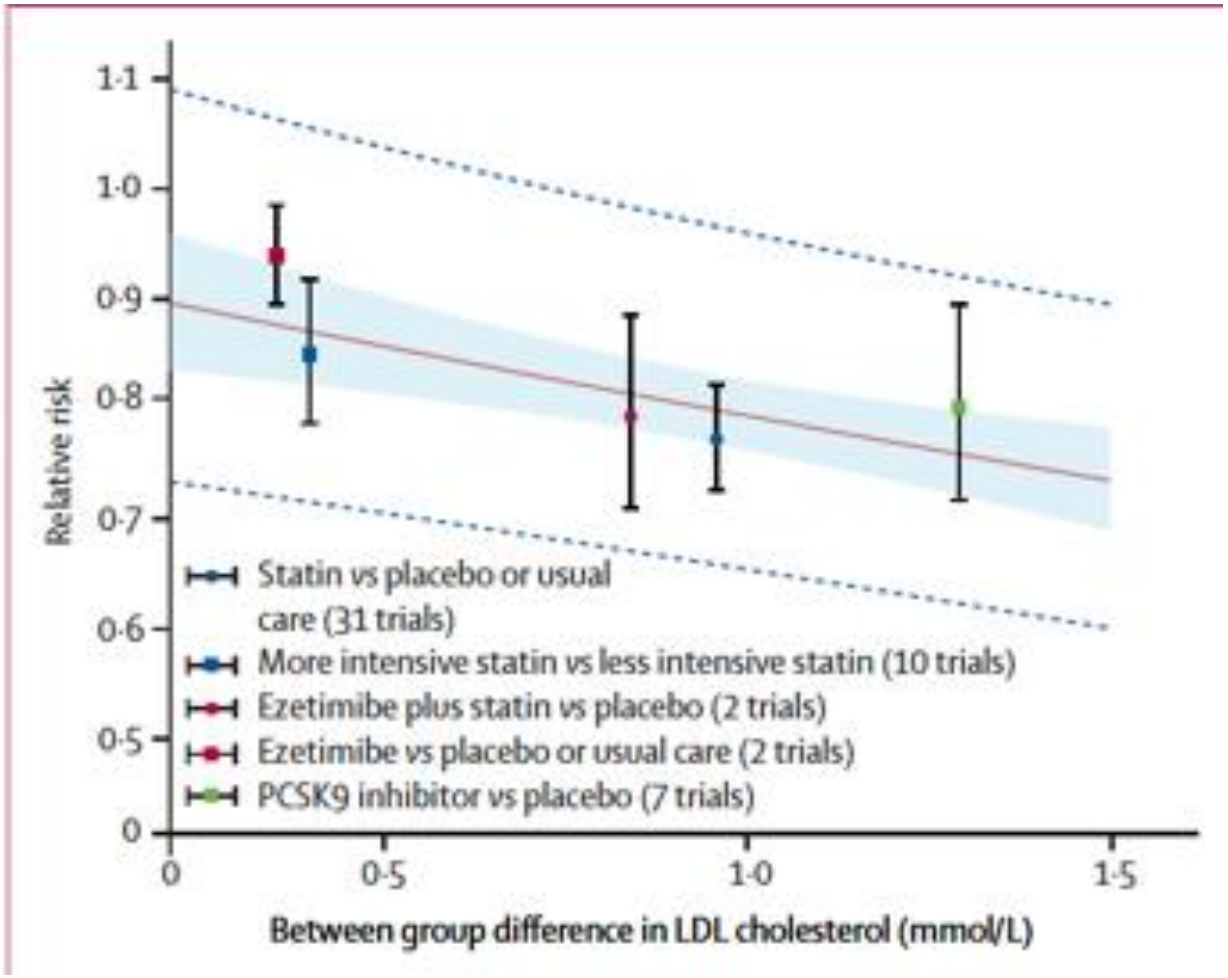
327377

1mmol/l = ↓ MACE del 19%.



Contribución de A1C, SBP, LDL e IMC a los resultados observados en los tres CVOT. Las barras azules, naranjas y rojas indican una reducción del riesgo en los resultados de los ensayos debido al control de A1C, SBP e IMC, respectivamente. En contraste, la barra verde indica el aumento de riesgo debido a los niveles de LDL aumentados después del uso de iSGLT2.

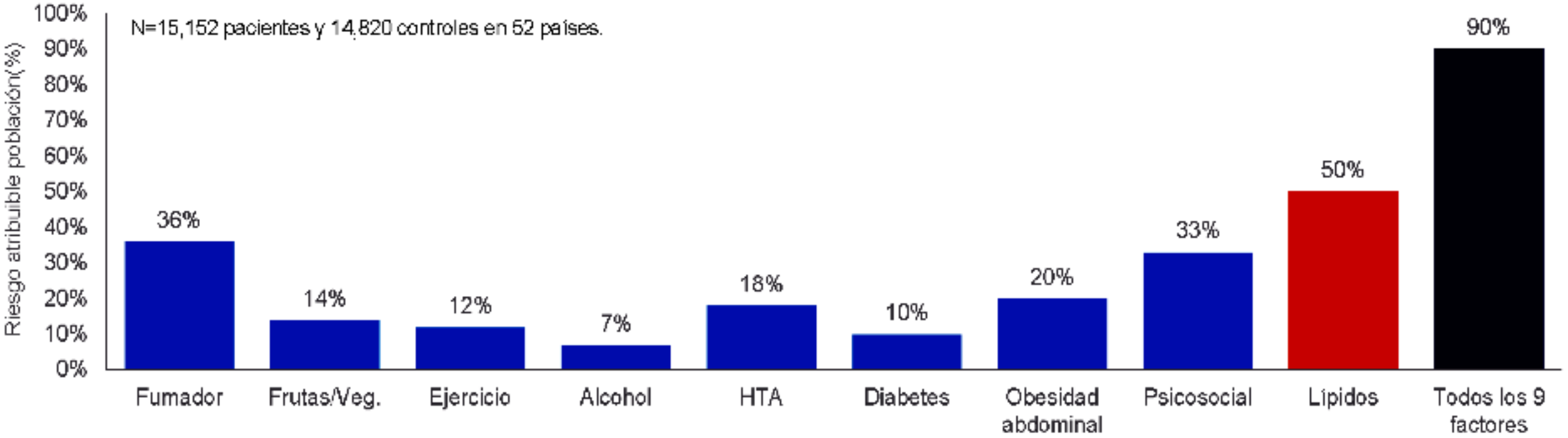
Diabetes Care. 2020;dc200227. doi:10.2337/dc20-0227



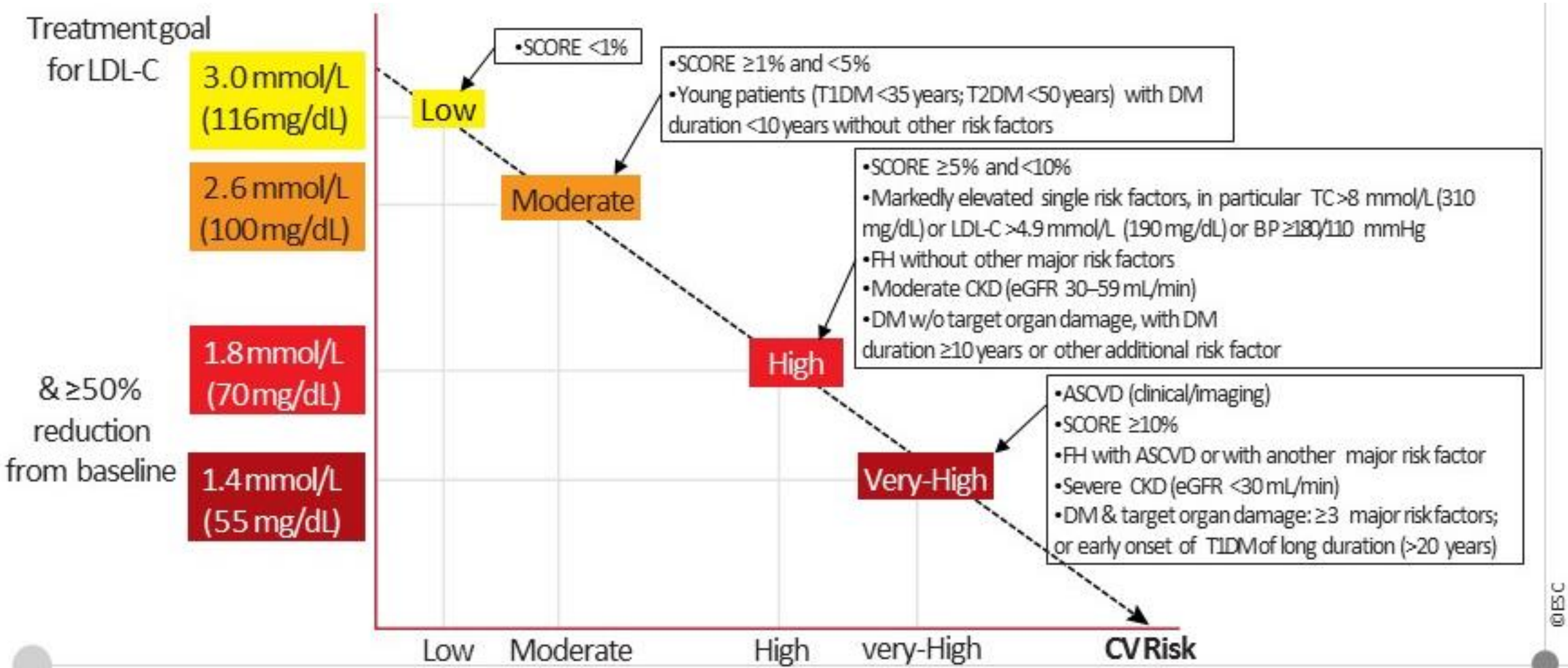
Wang N, Fulcher J, Abeysuriya N, et al. *Lancet Diabetes Endocrinol*. 2020;8(1):36-49.

Alsehli, A.M., Olivo, G., Clemensson, L.E. *et al.* The Cognitive Effects of Statins are Modified by Age. *Sci Rep* **10,** 6187 (2020)

Nueve factores de riesgo modificables representan ≥ 90% del riesgo de primer infarto de miocardio a nivel mundial

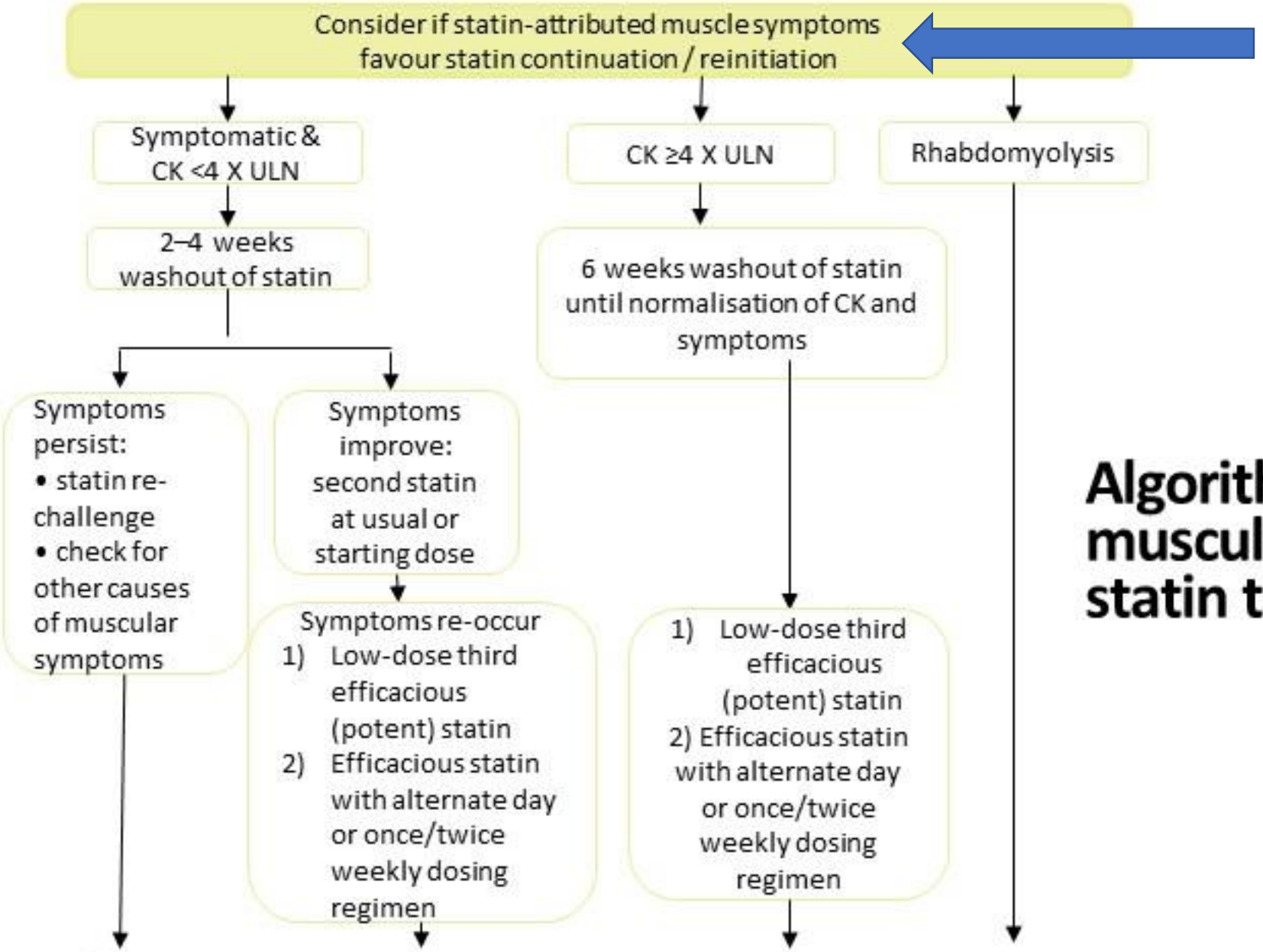


Pacientes con c-LDL > 100 mg/dL tienen ~4 veces mayor riesgo de MACE que aquellos con c-LDL < 50 mg/dL (17,6% vs. 4,4%)*



www.escardio.org/guidelines

2019 ESC/EAS Guidelines for the management of dyslipidaemias: lipid modification to reduce cardiovascular risk (European Heart Journal 2019 -doi: 10.1093/eurheartj/ehz455)



EAS ESC European Society of Cardiology

Algorithm for treatment of muscular symptoms during statin treatment (1)

www.escardio.org/guidelines

2019 ESC/EAS Guidelines for the management of dyslipidaemias: lipid modification to reduce cardiovascular risk (European Heart Journal 2019 -doi: 10.1093/eurheartj/ehz455)

Recommendations	Class	Level
Statin treatment is recommended as the first drug of choice for reducing CVD risk in high-risk individuals with hypertriglyceridaemia (TG >2.3 mmol/L (>200 mg/dL)).	I	B
In high-risk (or above) patients with TG between 1.5 and 5.6 mmol/L (135–499 mg/dL) despite statin treatment, n-3 PUFAs (icosapent ethyl 2 x 2 g/day) should be considered in combination with statin.	IIa	B

¿Cómo tratar el riesgo residual lipídico?

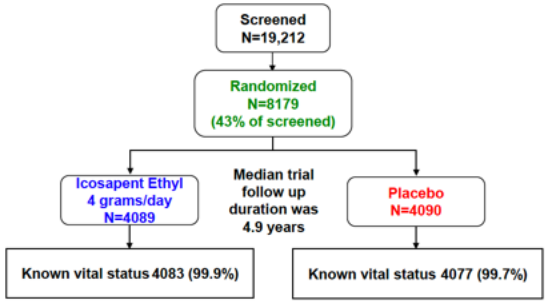
reduce-it

Reduction in Total Ischemic Events in the Reduction of Cardiovascular Events with Icosapent Ethyl–Intervention Trial

Deepak L. Bhatt, MD, MPH, Ph. Gabriel Steg, MD, Michael Miller, MD, Eliot A. Brinton, MD, Terry A. Jacobson, MD, Steven B. Ketchum, PhD, Ralph T. Doyle, Jr., BA, Rebecca A. Juliano, PhD, Lixia Jiao, PhD, Craig Granowitz, MD, PhD, Jean-Claude Tardif, MD, John Gregson, PhD, Stuart J. Pocock, PhD, Christie M. Ballantyne, MD, on Behalf of the REDUCE-IT Investigators

icosapentethyl 4g/day

REDUCE-IT Design



1. Age ≥45 years with established CVD (Secondary Prevention Cohort) *or* ≥50 years with diabetes with ≥1 additional risk factor for CVD (Primary Prevention Cohort)
2. Fasting TG levels ≥135 mg/dL and <500 mg/dL
3. LDL-C >40 mg/dL and ≤100 mg/dL and on stable statin therapy (± ezetimibe) for ≥4 weeks prior to qualifying measurements for randomization

Primary Endpoint Events: CV death, nonfatal MI, nonfatal stroke, coronary revasc, hospitalization for unstable angina

Key Secondary Endpoint Events: CV death, nonfatal MI, nonfatal stroke

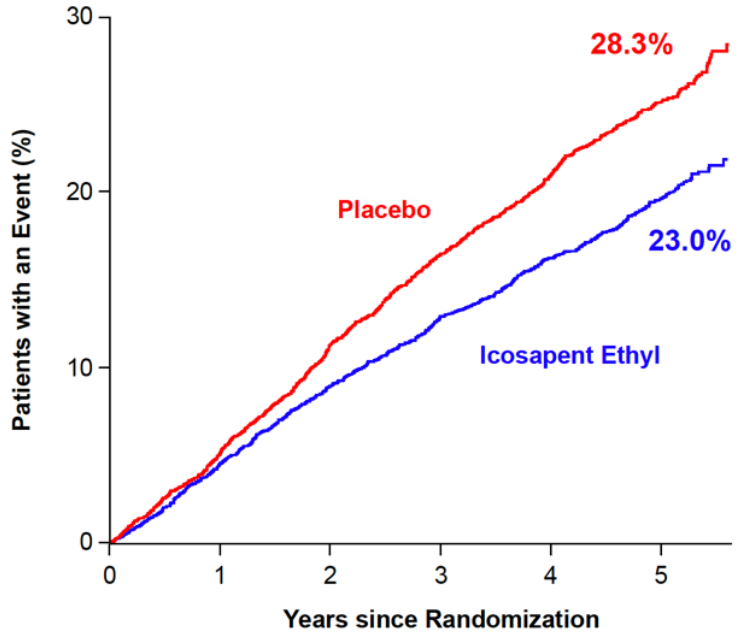
Double-blind study; Events adjudicated by CEC that was blinded to treatment during adjudication

Bhatt DL, Steg PG, Miller M, et al. *N Engl J Med.* 2019; 380:11-22.

Primary End Point:

CV Death, MI, Stroke, Coronary Revasc, Unstable Angina

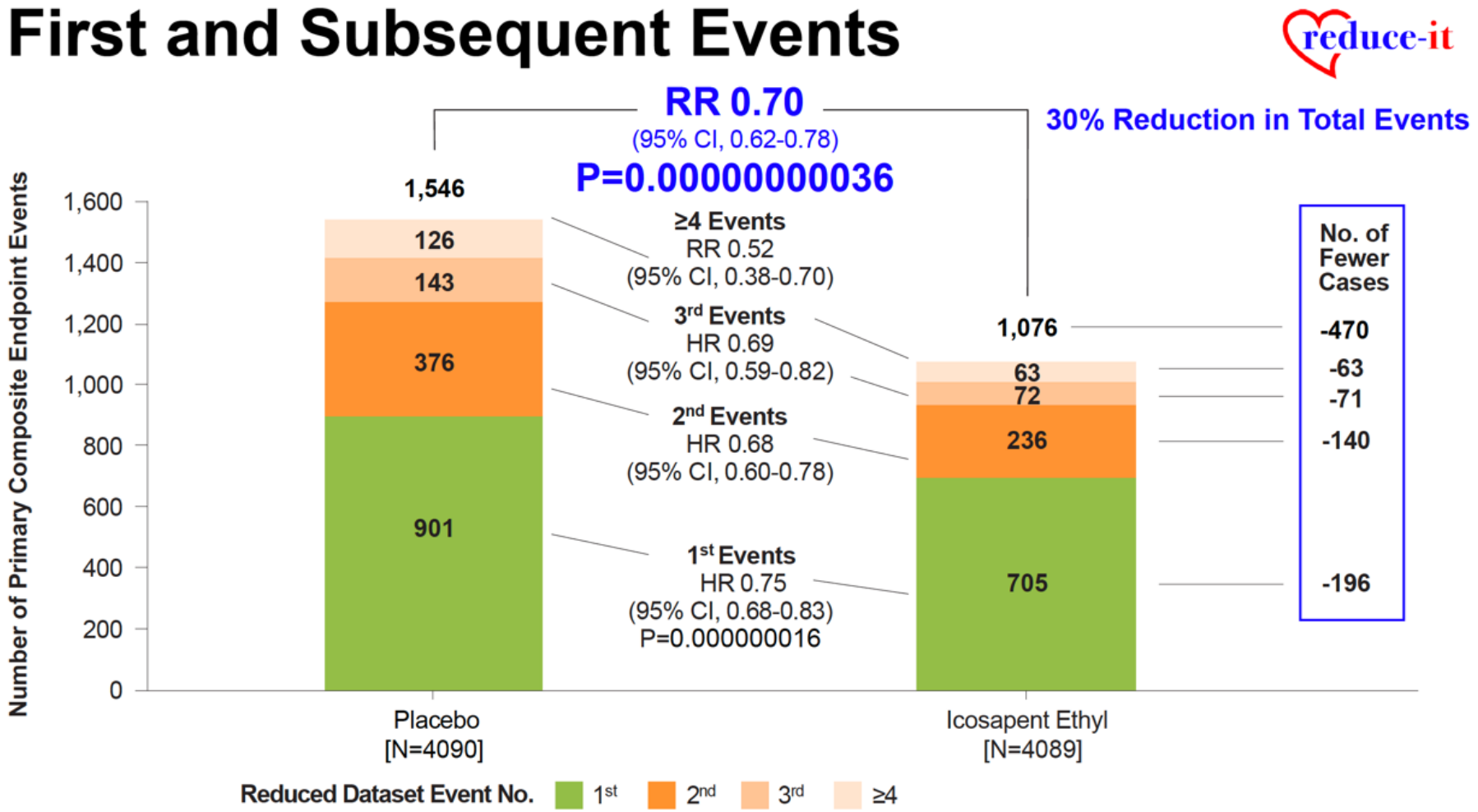
reduce-it



Hazard Ratio, 0.75
(95% CI, 0.68–0.83)
RRR = 24.8%
ARR = 4.8%
NNT = 21 (95% CI, 15–33)
P=0.00000001

Bhatt DL, Steg PG, Miller M, et al. *N Engl J Med.* 2019; 380:11-22. Bhatt DL. AHA 2018, Chicago.

¿Cómo tratar el riesgo residual lipídico?

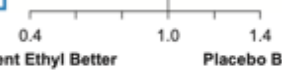


Bhatt DL, Steg PG, Miller M, et al. *J Am Coll Cardiol*. 2019.

Note: WLW method for the 1st events, 2nd events, and 3rd events categories
Negative binomial model for ≥4th events and overall treatment comparison.

Prespecified Hierarchical Testing

Endpoint	Hazard Ratio (95% CI)	Icosapent Ethyl n/N (%)	Placebo n/N (%)	Hazard Ratio (95% CI)	RRR	P-value
Primary Composite (ITT)		705/4089 (17.2%)	901/4090 (22.0%)	0.75 (0.68–0.83)	25%▼	<0.001
Key Secondary Composite (ITT)		459/4089 (11.2%)	606/4090 (14.8%)	0.74 (0.65–0.83)	26%▼	<0.001
Cardiovascular Death or Nonfatal Myocardial Infarction		392/4089 (9.6%)	507/4090 (12.4%)	0.75 (0.66–0.86)	25%▼	<0.001
Fatal or Nonfatal Myocardial Infarction		250/4089 (6.1%)	355/4090 (8.7%)	0.69 (0.58–0.81)	31%▼	<0.001
Urgent or Emergent Revascularization		216/4089 (5.3%)	321/4090 (7.8%)	0.65 (0.55–0.78)	35%▼	<0.001
Cardiovascular Death		174/4089 (4.3%)	213/4090 (5.2%)	0.80 (0.66–0.98)	20%▼	0.03
Hospitalization for Unstable Angina		108/4089 (2.6%)	157/4090 (3.8%)	0.68 (0.53–0.87)	32%▼	0.002
Fatal or Nonfatal Stroke		98/4089 (2.4%)	134/4090 (3.3%)	0.72 (0.55–0.93)	28%▼	0.01
Total Mortality, Nonfatal Myocardial Infarction, or Nonfatal Stroke		549/4089 (13.4%)	690/4090 (16.9%)	0.77 (0.69–0.86)	23%▼	<0.001
Total Mortality		274/4089 (6.7%)	310/4090 (7.6%)	0.87 (0.74–1.02)	13%▼	0.09

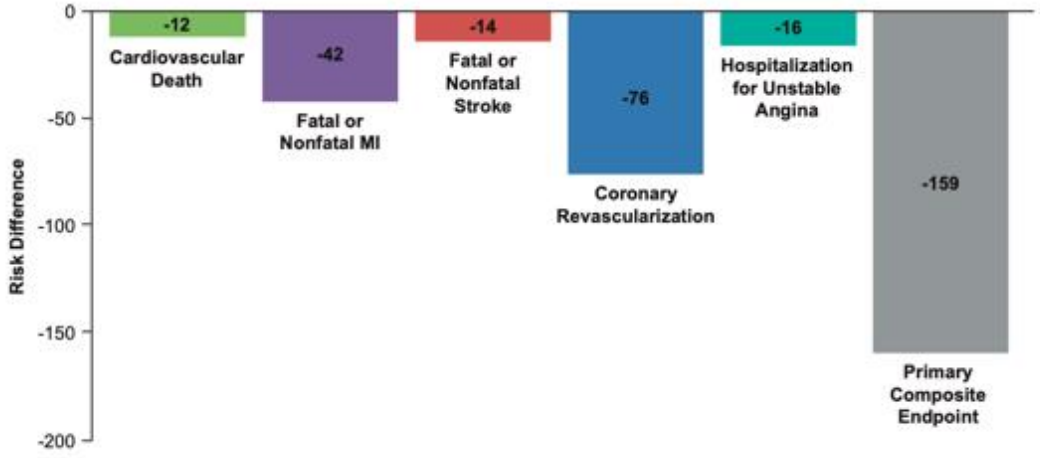


RRR denotes relative risk reduction

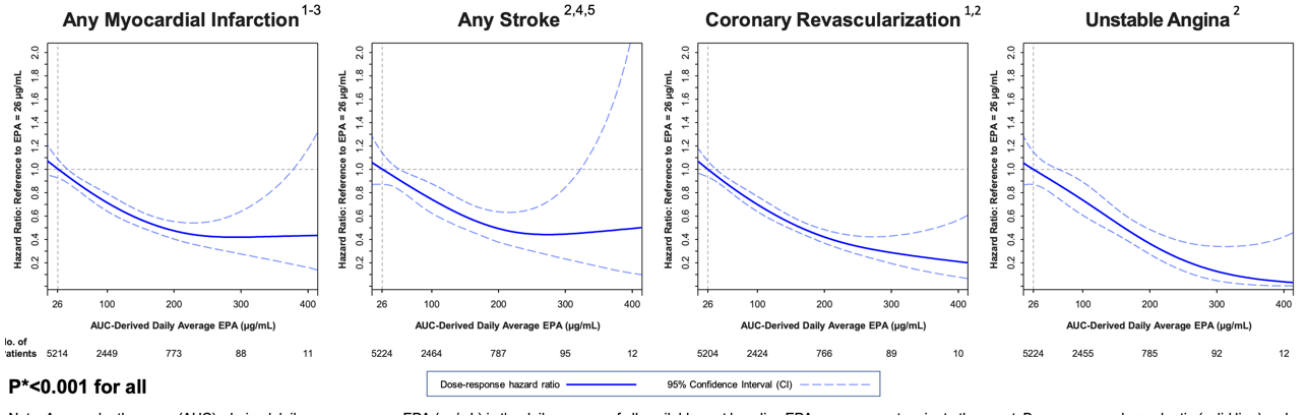
Bhatt DL. AHA 2018, Chicago.

Bhatt DL, Steg PG, Miller M, et al. *N Engl J Med.* 2019.

For Every 1000 Patients Treated with Icosapent Ethyl for 5 Years:

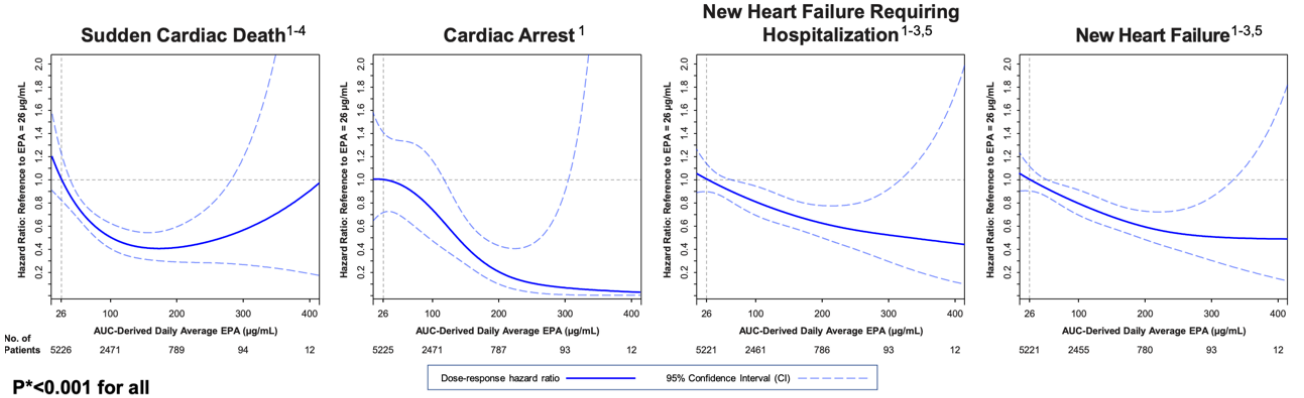


Dose-Response of Hazard Ratio (95% CI) Any Myocardial Infarction, Any Stroke, Coronary Revascularization, Unstable Angina by On-Treatment Serum EPA



P*<0.001 for all

Dose-Response of Hazard Ratio (95% CI) Sudden Cardiac Death, Cardiac Arrest, New Heart Failure Requiring Hospitalization, New Heart Failure by On-Treatment Serum EPA

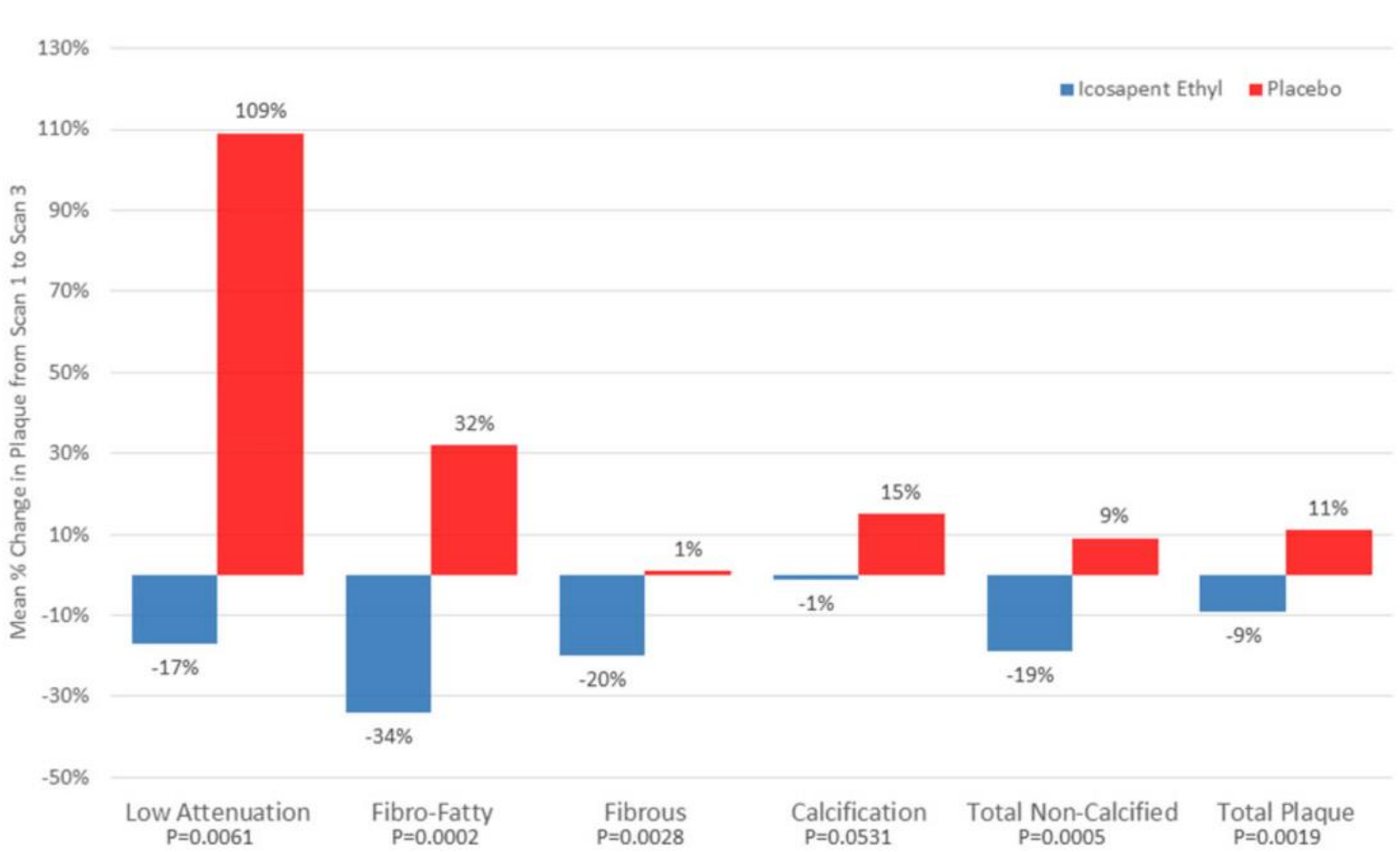


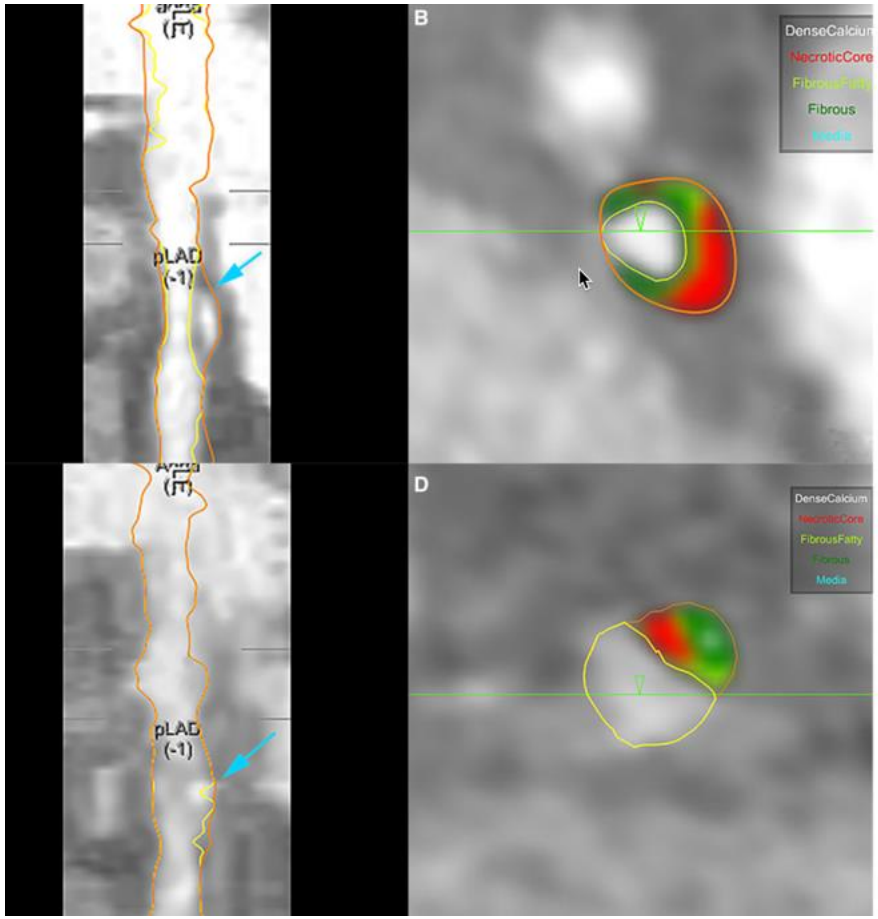
P*<0.001 for all

Note: On-treatment post baseline serum EPA (µg/mL) is the daily average of all available post baseline EPA measurements prior to the event. Dose-response hazard ratio (solid line) and 95% CI (dotted lines) are [illegible] from the Cox proportional hazard model with a spline term for EPA and adjustment for randomization factors and statin compliance[1], baseline diabetes[2], and hsCRP[3], treatment compliance[4] age[5].
*P value is <0.001 for both non-linear trend and for regression slope.

Bhatt DL. ACC/WCC 2020, Chicago (virtual).

evaporate
FINAL





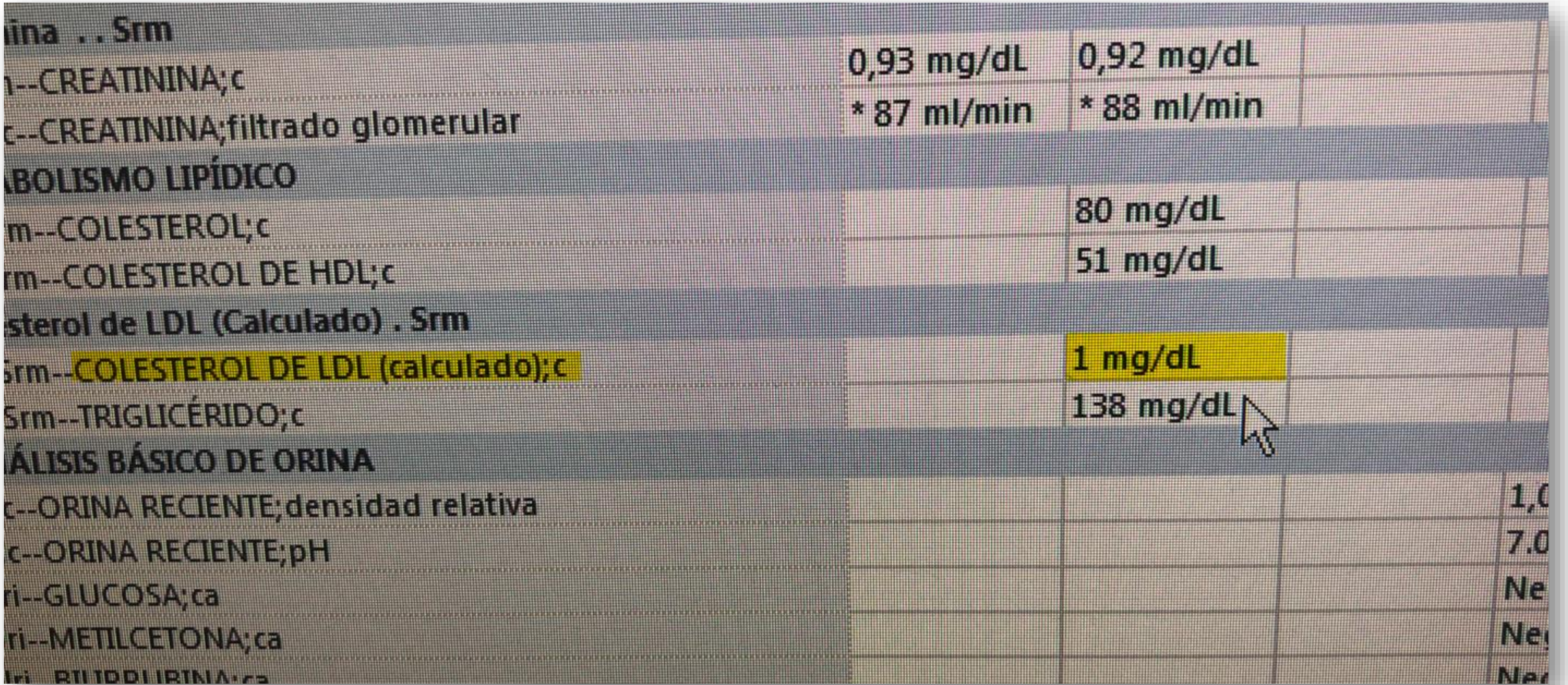
Matthew J Budoff, et al Effect of icosapent ethyl on progression of coronary atherosclerosis in patients with elevated triglycerides on statin therapy: final results of the EVAPORATE trial, *European Heart Journal*, , ehaa652

Achievable reductions of low-density lipoprotein cholesterol as a function of the therapeutic approach

EAS ESC European Society of Cardiology

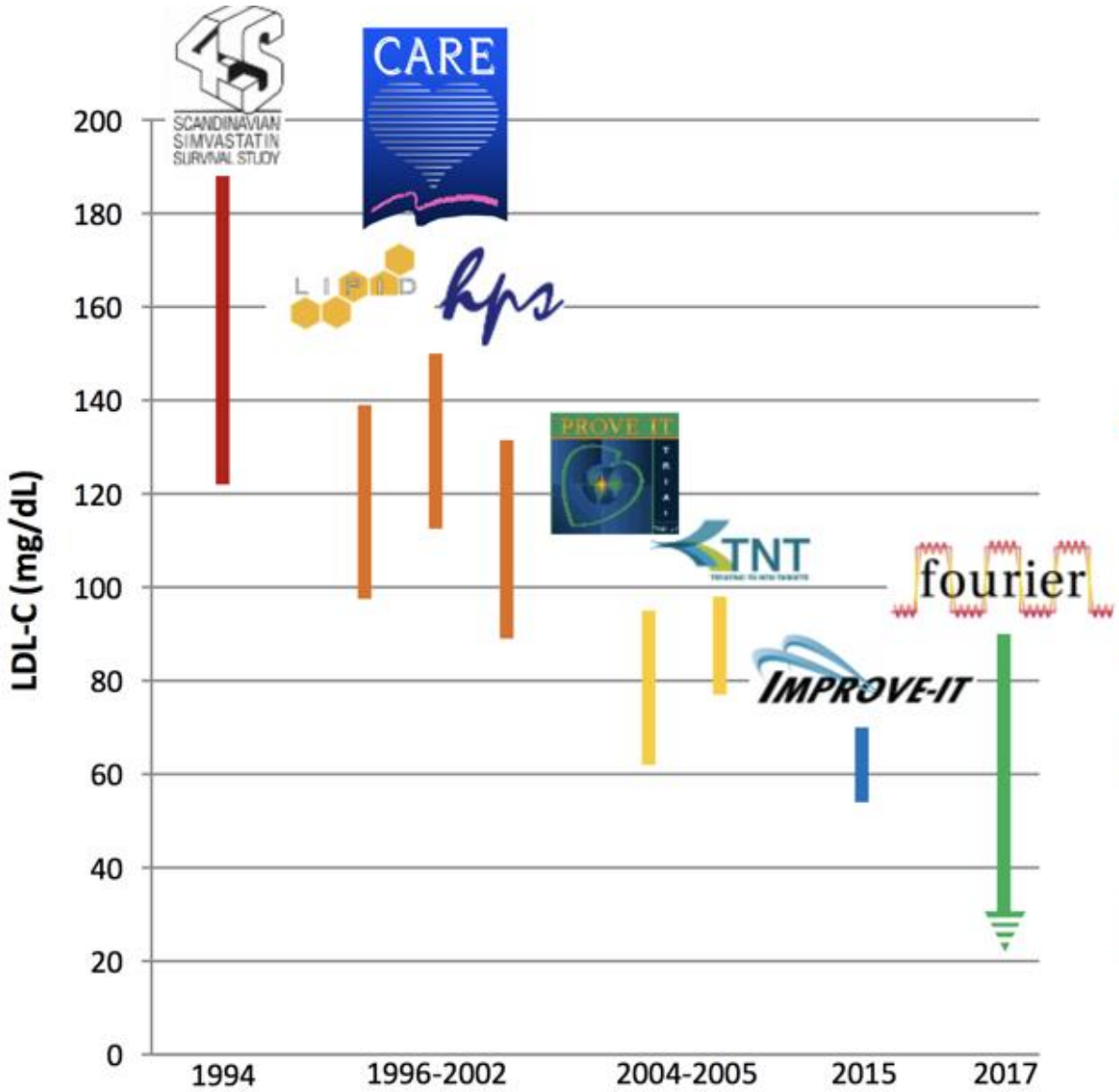
LDL-C, mmol/L (mg/dL)	Reduction obtainable with different therapeutic strategies				
	Moderate-intensity statins		High-intensity statins		PCSK9 inhibitor plus high-intensity statin
		Plus ezetimibe		Plus ezetimibe	
4.5	3.2	2.5	2.3	1.6	0.9
(175)	(123)	(96)	(88)	(61)	(35)
4.3	3.0	2.4	2.2	1.5	0.9
(165)	(116)	(91)	(83)	(58)	(33)
4.0	2.8	2.2	2.0	1.4	0.8
(155)	(109)	(85)	(78)	(54)	(31)
3.7	2.6	2.0	1.9	1.3	0.7
(145)	(102)	(80)	(73)	(51)	(29)
3.5	2.5	1.9	1.8	1.2	0.7
(135)	(95)	(74)	(68)	(47)	(27)
3.2	2.2	1.8	1.6	1.1	0.6
(125)	(88)	(69)	(63)	(44)	(25)
3.0	2.1	1.7	1.5	1.1	0.6
(116)	(81)	(63)	(58)	(40)	(23)
2.7	1.9	1.5	1.4	0.9	0.5
(105)	(74)	(58)	(53)	(37)	(21)
2.5	1.8	1.4	1.3	0.9	0.5
(95)	(67)	(52)	(48)	(33)	(19)
2.2	1.5	1.2	1.1	0.8	0.4
(85)	(60)	(47)	(43)	(30)	(17)
1.9	1.3	1.0	1.0	0.7	0.4
(75)	(53)	(41)	(38)	(26)	(15)

The Task Force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and European Atherosclerosis Society (EAS), European Heart Journal, Volume 41, Issue 1, 1 January 2020, Pages 111–188



ina . . Srm		
--CREATININA;c	0,93 mg/dL	0,92 mg/dL
c--CREATININA;filtrado glomerular	* 87 ml/min	* 88 ml/min
ABOLISMO LIPÍDICO		
m--COLESTEROL;c		80 mg/dL
rm--COLESTEROL DE HDL;c		51 mg/dL
sterol de LDL (Calculado) . Srm		
Srm--COLESTEROL DE LDL (calculado);c		1 mg/dL
Srm--TRIGLICÉRIDO;c		138 mg/dL
ÁLISIS BÁSICO DE ORINA		
c--ORINA RECIENTE;densidad relativa		
c--ORINA RECIENTE;pH		
ri--GLUCOSA;ca		
ri--METILCETONA;ca		
ri--BILIRRUBINA;ca		

Grandes descensos de c-LDL se asocian con grandes reducciones en la tasa de eventos CV



High is bad

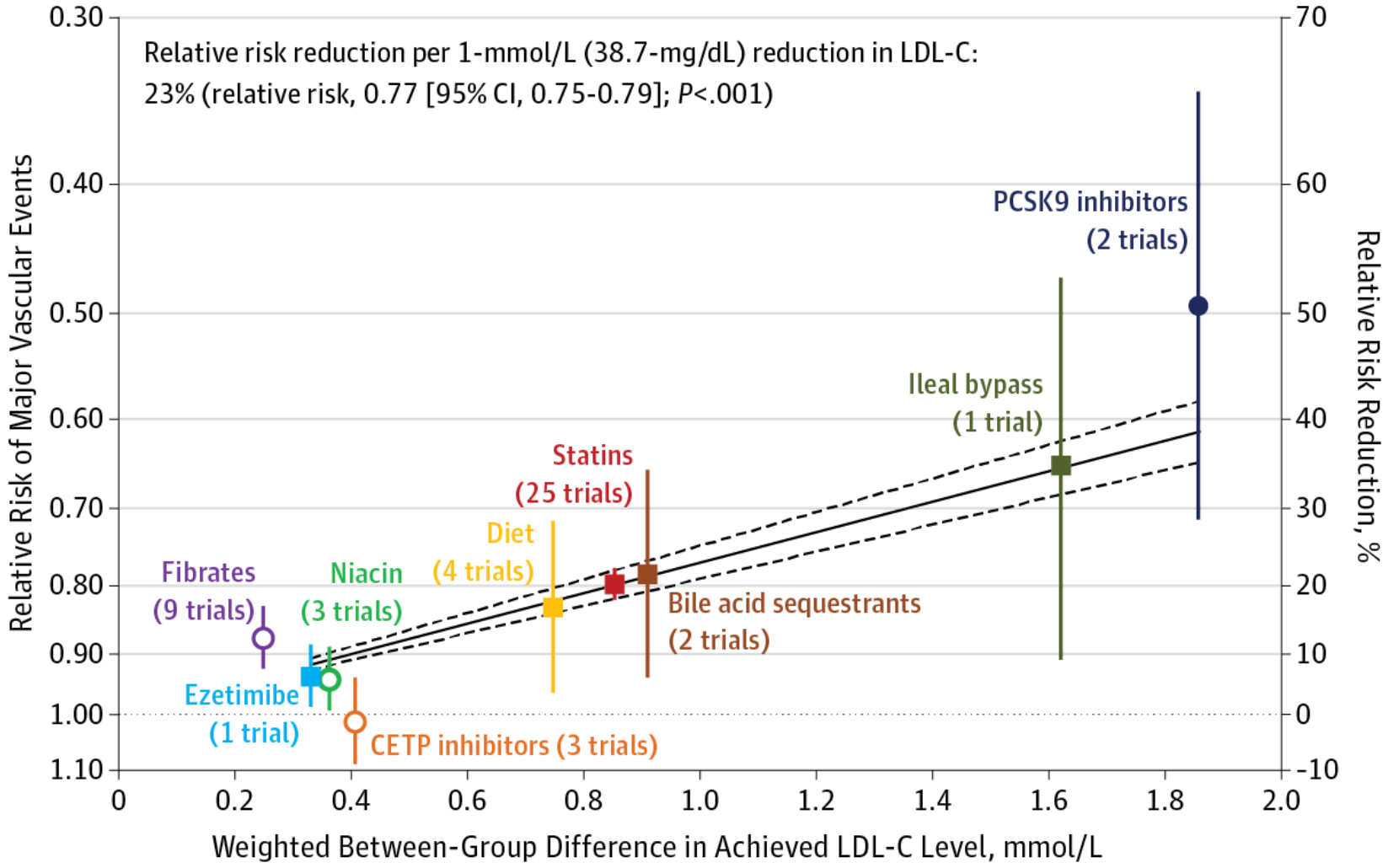
Average is not good

Lower is better

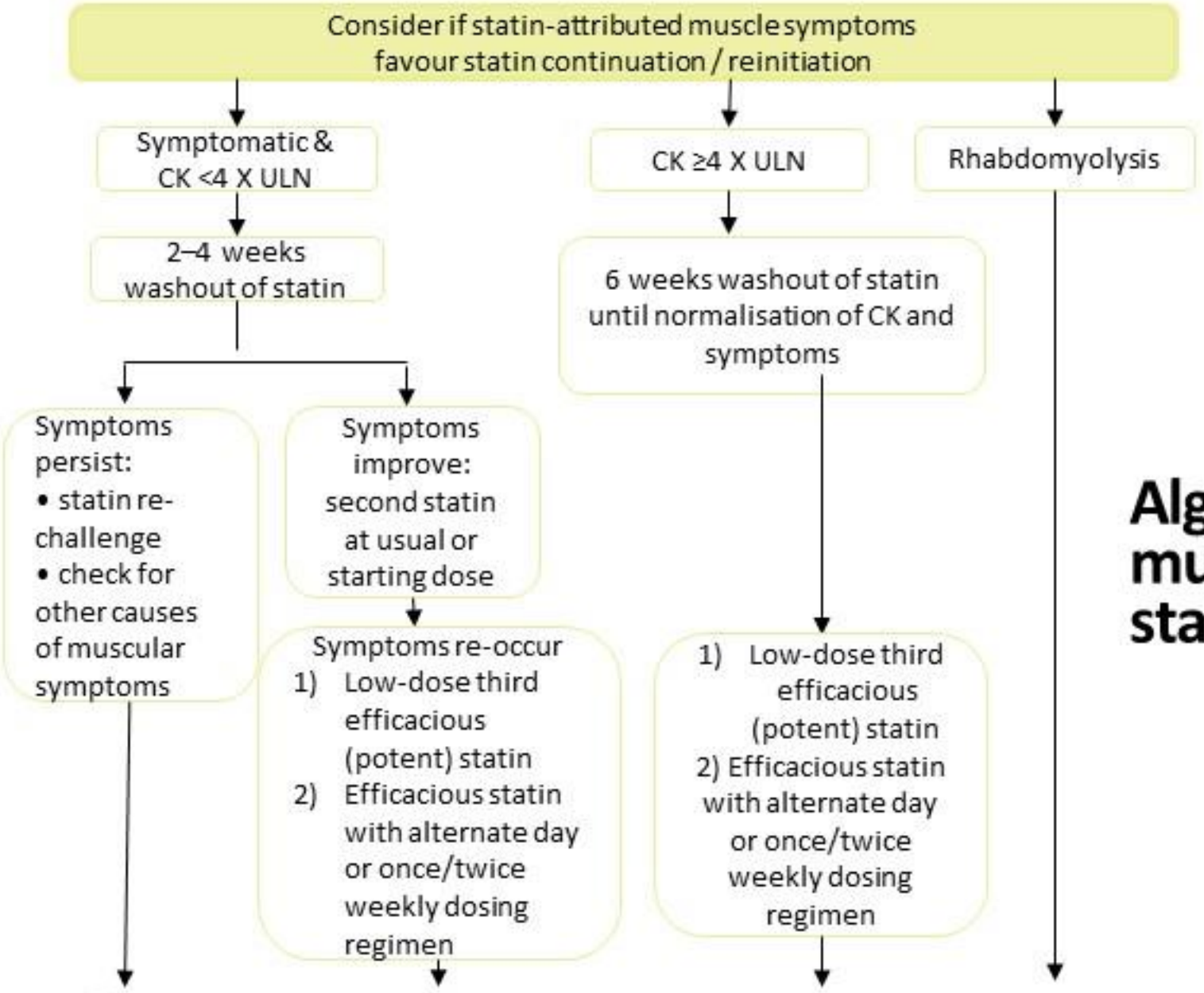
Even lower is even better

Lowest is best

Grandes descensos de c-LDL se asocian con grandes reducciones en la tasa de eventos CV



Silverman MG, et al. JAMA 2016; 316: 1289-1297



EAS ESC European Society of Cardiology

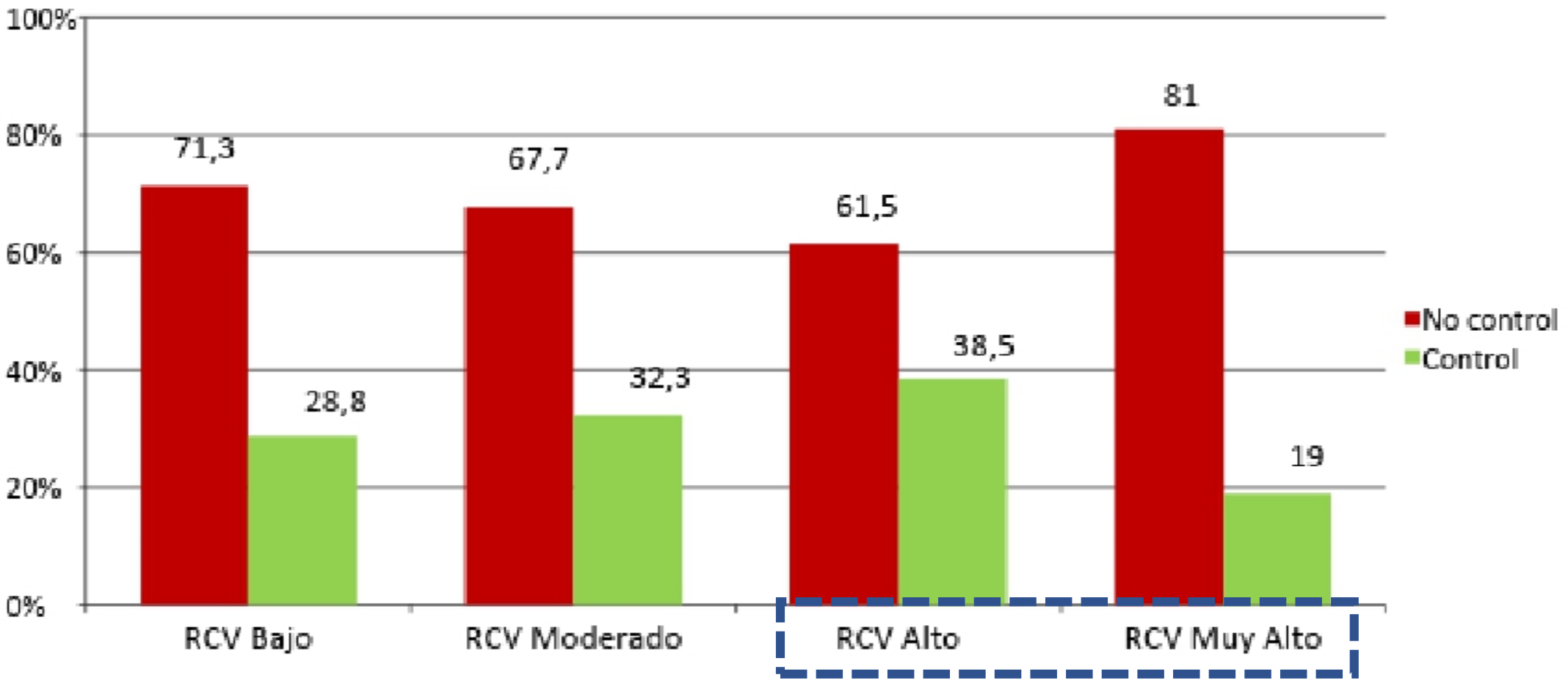
Algorithm for treatment of muscular symptoms during statin treatment (1)

www.escardio.org/guidelines

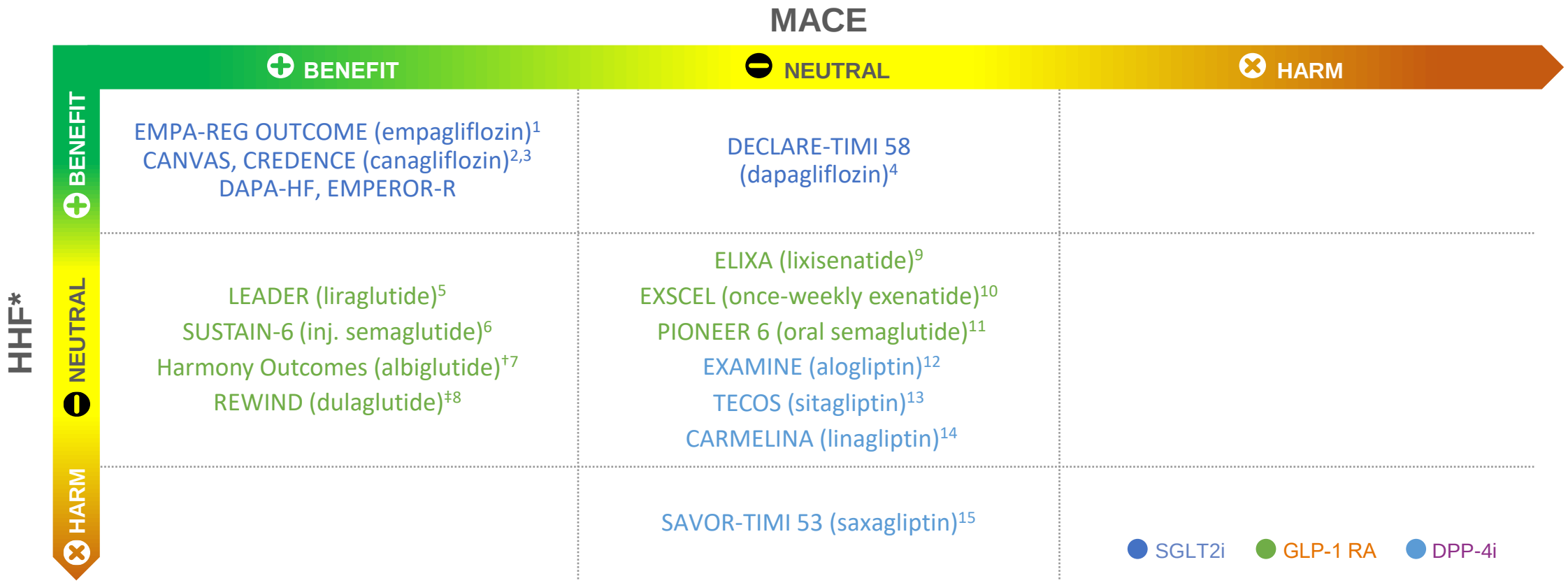
2019 ESC/EAS Guidelines for the management of dyslipidaemias: lipid modification to reduce cardiovascular risk (European Heart Journal 2019 -doi: 10.1093/eurheartj/ehz455)

ESTUDIO IBERICAN

Identificación de la poBlación Española de RIesgo CArdio Vascular y reNal



Estudio IBERICAN. Agencia de Investigación. Fundación SEMERGEN



Comparison of trials should be interpreted with caution due to differences in study design, populations and methodology

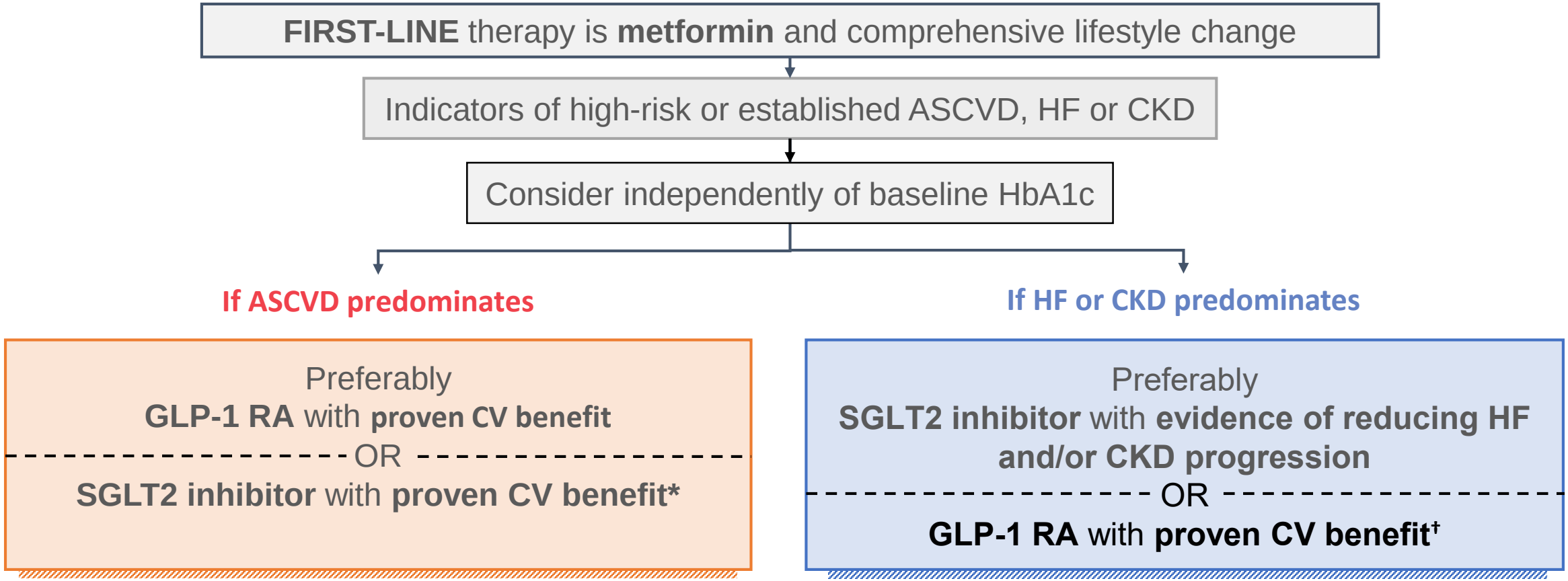
Empagliflozin is FDA-approved to reduce the risk of CV death

Dapagliflozin is FDA-approved to reduce the risk of HHF in adults with T2D and established CV disease or multiple CV risk factors

*Exploratory outcome in all trials except for CREDENCE; †CV death or HHF was a composite secondary endpoint; HHF data alone were not reported in the primary publication[7]; ‡HF outcome was hospital admission for HF or urgent visit

See slide notes for abbreviations and full list of references

- 2019 ADA–EASD Consensus Report update and 2020 ADA Standards of Medical Care in Diabetes[1,2]

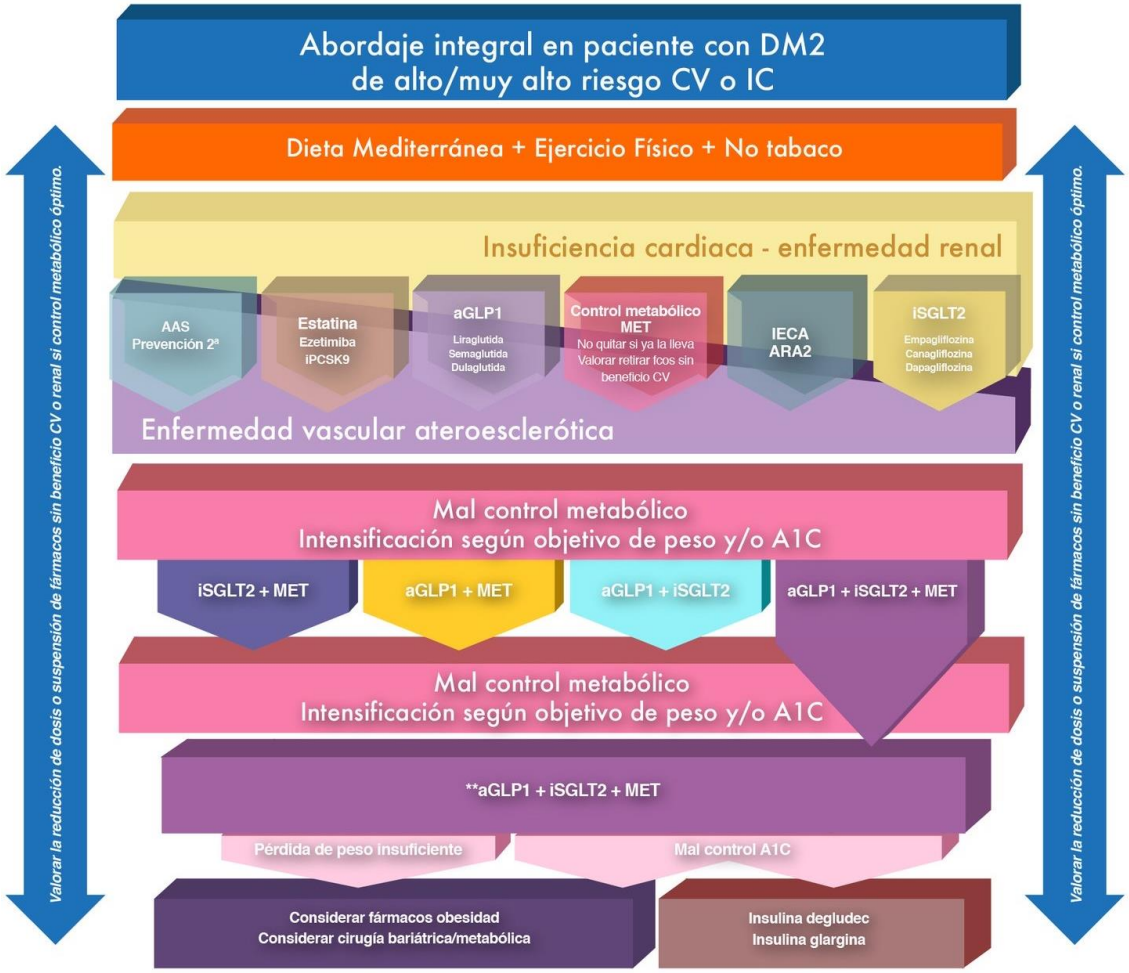


*If eGFR adequate; †If SGLT2 inhibitor not tolerated or contraindicated or if eGFR is less than adequate

ADA, American Diabetes Association; ASCVD, atherosclerotic cardiovascular disease; EASD, European Association for the Study of Diabetes

1. Buse JB *et al. Diabetes Care* 2020;43:487; 2. American Diabetes Association. *Diabetes Care* 2020;43:S1

https://secardiologia.es/images/algoritmo-diabetes-alto-riesgo.jpg



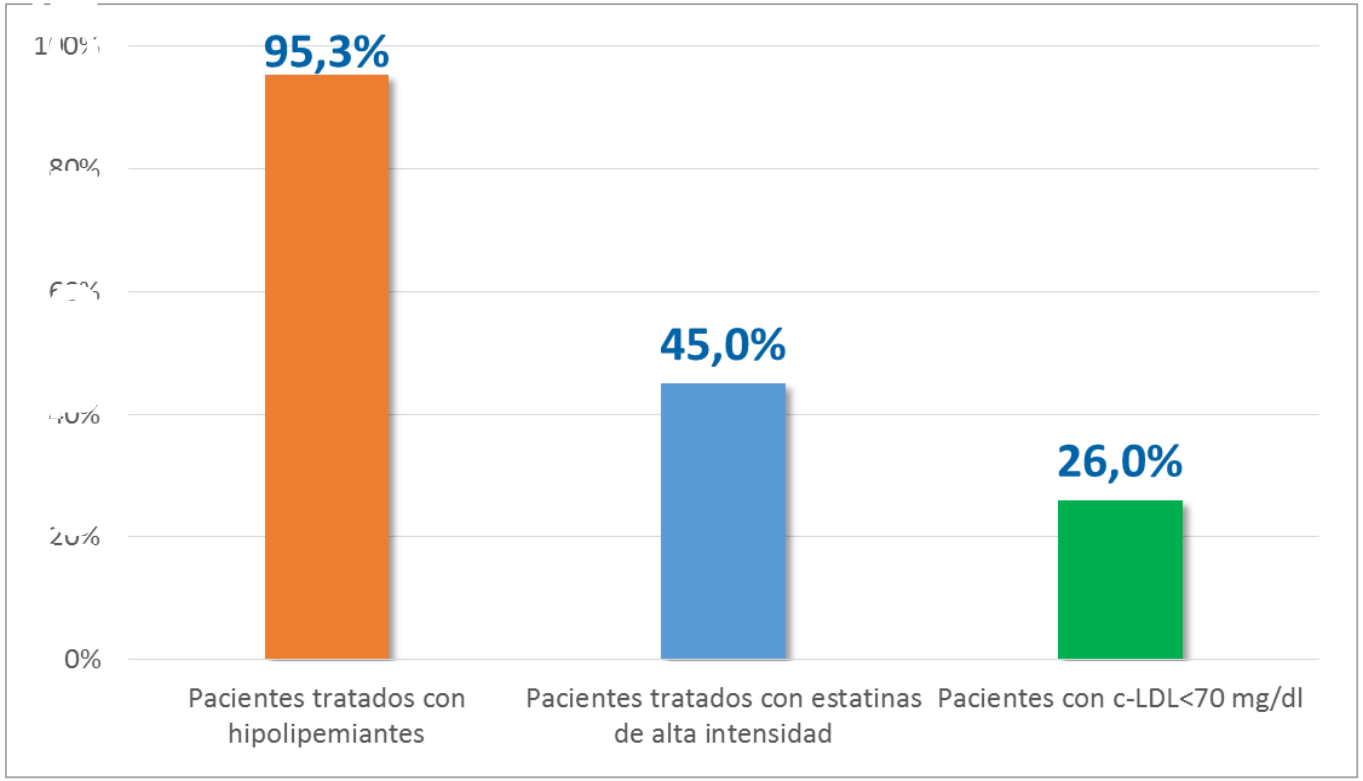
**En caso de contraindicación o intolerancia a aGLP1 valorar iDPP4 como alternativa terapéutica por su efecto neutro sobre peso, hipoglucemias y riesgo CV

MET: Metformina
iSGLT2: Inhibidores del cotransportador de sodio-glucosa tipo 2
aGLP1: Análogos del péptido similar al glucagón tipo 1

SOCIEDAD ESPAÑOLA DE CARDIOLOGÍA | Asociación de Riesgo Vascular y Rehabilitación Cardiaca | Grupo de Diabetes y Obesidad

geendiab Grupo Español de Estudio de la Nefropatía Diabética

Estudio REPAR:
Grado de control lipídico en pacientes coronarios y medidas adoptadas por los médicos



- En España, sólo el **26%** de los pacientes logran el **objetivo de c-LDL** en **prevención secundaria.**
- Existe una **infrautilización del tratamiento hipolipemiante:**
  - **45%: estatinas de alta intensidad**
  - **14%: ezetimiba**
- **La inercia terapéutica es frecuente en prevención secundaria:** No se amplía el tratamiento en un **70% de casos.**

Adaptado de Galve E, et al. Rev Esp Cardiol. 2016;69:931–938

Achievable reductions of low-density lipoprotein cholesterol as a function of the therapeutic approach

EAS ESC European Society of Cardiology

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The Task Force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and European Atherosclerosis Society (EAS), European Heart Journal, Volume 41, Issue 1, 1 January 2020, Pages 111–188

Clasificación de la terapia hipolipemiante según su eficacia terapéutica para reducir el cLDL

Intesidad de reducción de cLDL	Alternativas terapéuticas
Reducción extrema (76-85%)	Tratamiento hipolipemiante máximo de base más inhibidores de PCSK9*: • Evolocumab 140 mg (~85%) • Alirocumab 75 mg (~76%) • Alirocumab 150 mg (~85%)
Reducción muy elevada (60-75%)	Estatinas potentes + ezetimiba: • Atorvastatina 40-80 mg + ezetimiba 10 mg • Rosuvastatina 10-40 mg + ezetimiba 10 mg
Reducción elevada (50-59%)	Estatina alta potencia: • Atorvastatina 40-80 mg • Rosuvastatina 20-40 mg Estatina potencia intermedia + ezetimiba: • Simvastatina 20-40 mg + ezetimiba 10 mg • Pravastatina 40 mg + ezetimiba 10 mg • Lovastatina 40 mg + ezetimiba 10 mg • Fluvastatina 80 mg + ezetimiba 10 mg • Pitavastatina 2-4 mg + ezetimiba 10 mg • Atorvastatina 10-20 mg + ezetimiba 10 mg • Rosuvastatina 5 mg + ezetimiba 10 mg
Reducción moderada (30-49%)	Estatina de potencia intermedia: • Atorvastatina 10-20 mg • Rosuvastatina 5-10 mg • Simvastatina 20-40 mg • Pravastatina 40 mg • Lovastatina 40 mg • Pitavastatina 2-4 mg • Fluvastatina XL 80 mg Estatina baja potencia + ezetimiba: • Simvastatina 10 mg + ezetimiba 10 mg • Pravastatina 20 mg + ezetimiba 10 mg • Lovastatina 20 mg + ezetimiba 10 mg • Fluvastatina 40 mg + ezetimiba 10 mg • Pitavastatina 1 mg + ezetimiba 10 mg

Intensity of lipid lowering treatment

Treatment	Average LDL-C reduction
Moderate intensity statin	≈ 30%
High intensity statin	≈ 50%
High intensity statin plus ezetimibe	≈ 65%
PCSK9 inhibitor	≈ 60%
PCSK9 inhibitor plus high intensity statin	≈ 75%
PCSK9 inhibitor plus high intensity statin plus ezetimibe	≈ 85%

1. RECOMENDACIONES AL ALTA

Es clave evitar la inercia terapéutica, ya que no se intensificaba el tratamiento en el 70% de los casos de control insuficiente. Y eso a pesar de la evidencia científica tan importante sobre el **beneficio CV** del tratamiento hipolipemiante, tanto en el empleo de **estatinas de alta intensidad, como la atorvastatina, que tiene indicación específica en la prevención de la enfermedad CV, como con la combinación de atorvastatina con ezetimiba.** Por ello, se recomienda seguir los algoritmos del documento SEC junto a las recomendaciones para el paciente en el link adjunto


MODELO DE INFORME AL ALTA SCA — PRO CORC

1- Schiele, F. et al. (2019) 'Proposal for a standardized discharge letter after hospital stay for acute myocardial infarction', European Heart Journal. Acute Cardiovascular Care.

PROPUESTA DE MODELO ESTANDARIZADO DE INFORME AL ALTA PARA PACIENTES CON INFARTO AGUDO DE MIOCARDIO

Se llegó a un acuerdo general sobre el uso de un formato estructurado. Los ocho puntos del informe de alta estructurado después de un infarto agudo de miocardio.

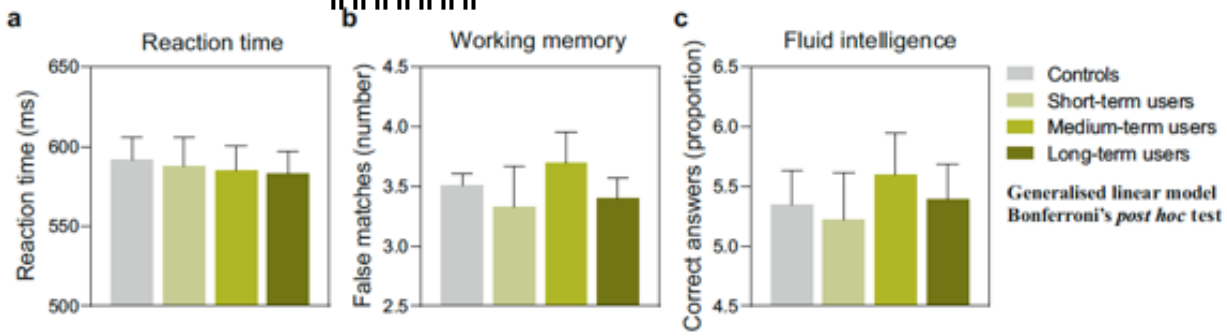
RECOMENDACIONES A PACIENTES

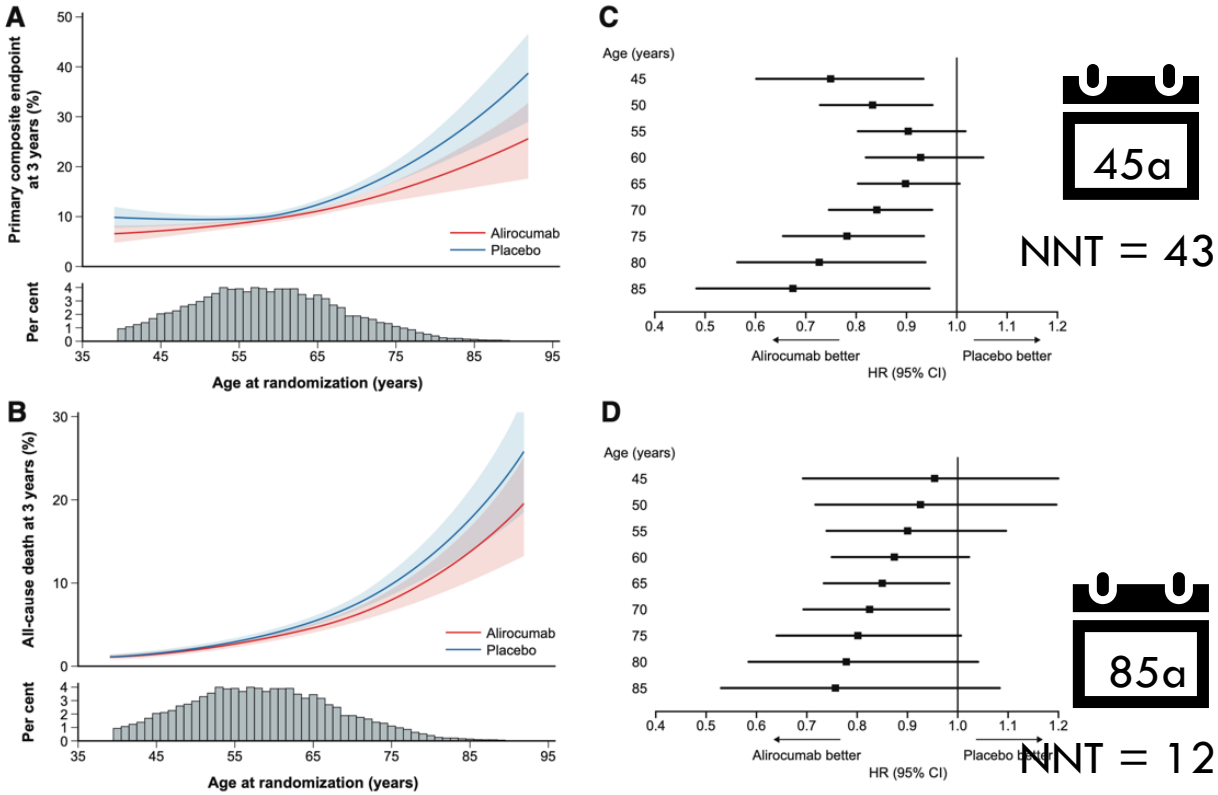
RECOMENDACIONES AL ALTA

RECOMENDACIONES (ABUCASIS)

RECOMENDACION INFORME MEDICO

245731 controles y
55,114 estatina > 10a





45a

NNT = 43

85a

NNT = 12

Alsehli, A.M., Olivo, G., Clemensson, L.E. *et al.* The Cognitive Effects of Statins are Modified by Age. *Sci Rep* **10,** 6187 (2020)


SEMERGEN AP
SOCIEDAD VALENCIANA DE CARDIOLOGÍA
PROCORC
Proyecto de SVC y SEMERGEN-CV para la mejora en el proceso asistencial del paciente en prevención secundaria tras SCA
ACCEDER