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New Guideline and Evidence to Improve Management of Patients with or at High-Risk of Atherosclerotic Cardiovascular Disease (ASCVD)

Margo B. Minissian, PhD, ACNP, FAHA, FNLA
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Identified or perceived conflict of interest has been resolved
in accordance with ACCME guidelines.

1

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Objectives

- Screen and diagnose female patients at high risk of cardiovascular events during their annual visit
- Describe the impact of residual ASCVD risk that remains beyond statin therapy
- Apply evidence-based guidelines and recent randomized clinical trial evidence to lifestyle and pharmacologic adjuncts to statin therapy to manage women at risk of ASCVD events

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Identifying Women at Risk for ASCVD

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3

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Faculty Disclosure

Dr. Minissian receives consulting fees from Amgen

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Only ~Half of Women* Know that Heart Disease Is Their #1 Killer

- **Heart disease is the #1 cause of death for women** in the US, killing 299,578 women in 2015 (22.3% of all deaths)
 - Heart disease kills **4-times more women than breast cancer**
- **Stroke is the #4 cause of death for women** in the US
 - In 2011, stroke caused the death of 76,597 females (59.4% of total stroke deaths)
- **Women are more likely to die from heart disease and stroke **than men****

*56%

<https://www.cdc.gov/heartdisease/women.htm> <https://www.cdc.gov/women/lcod/2015/race-ethnicity/index.htm>
https://www.heart.org/idc/groups/heart-public/@wcm/@sop/@smd/documents/downloadable/ucm_472913.pdf

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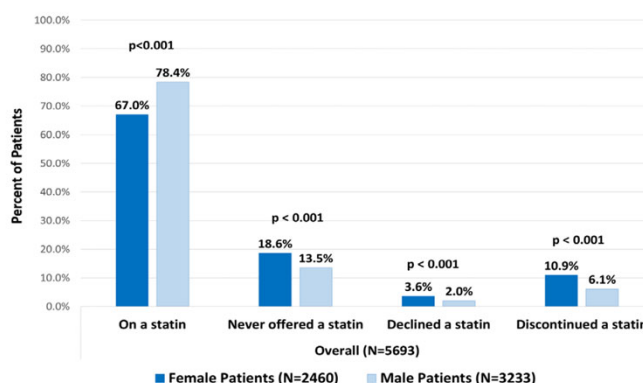
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Undertreatment: Women Receive Less Statin Therapy Than Men*



Women also receive less therapy than men for hypertension, CAD, heart failure

*Patient and Provider Assessment of Lipid Management (PALM) Registry; N=5693 (43% women) eligible for statins per 2013 ACC/AHA Guidelines

Nanna MG, et al. Circ Cardiovasc Qual Outcomes. 2019;12:e005562. Epub ahead of print.

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The Evaluation of CV Risk Factors and Symptoms in Women Remains Challenging

Established risk factors common to both genders

Psychological stress

Smoking

Hypertension

History of CAD or other atherosclerotic vascular disease

Diabetes mellitus

Chronic kidney disease

Inflammatory disorders e.g. RA

Dyslipidemia: high LDL and/or low HDL

Age >55 years

Family history of premature CAD



Risk factors specific to women

Postmenopausal

Pregnancy complications:
• pre-eclampsia
• gestational diabetes

Influence of Gender on ASCVD Symptoms

Common in both Sexes	Greater impact on Women
Pain, pressure, or squeezing in chest	Report milder symptoms
Radiation of pain to neck, shoulder, back, arm, jaw	Sudden onset of weakness, shortness of breath, fatigue feeling of systematic illness (w/o chest pain)
Palpitations	Diabetes
Difficulty in breathing	Autoimmune diseases
Dizziness	Heartburn, nausea, vomiting, abdominal pain
	Cold sweats, clamminess

Cardiac/coronary symptoms in women are “atypical” and therefore ACS/MI/Angina are way UNDER-diagnosed in women, creating a very dangerous situation

After Ketepe-Arachi T, Sharma S. European Cardiology Review 2017;12:10-13.

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ASCVD Risk Assessment, Hypertriglyceridemia, and Management Strategies in Women



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ACC Risk Calculator Plus to Assess Risk Category

Current Age ^{*} Age must be between 20-79

Sex ^{*}

Race ^{*}

Systolic Blood Pressure (mm Hg) ^{*} Value must be between 90-200

Diastolic Blood Pressure (mm Hg) ^{*} Value must be between 60-130

Total Cholesterol (mg/dL) ^{*} Value must be between 130 - 320

HDL Cholesterol (mg/dL) ^{*} Value must be between 20 - 100

LDL Cholesterol (mg/dL) ^{*} Value must be between 30-300

History of Diabetes? ^{*}

Smoker: ^{*}

On Hypertension Treatment? ^{*}

On a Statin? ^{*}

On Aspirin Therapy? ^{*}

Then use the new AHA/ACC Blood Cholesterol Guideline Algorithm for Primary Prevention to guide management

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9

ACC/AHA Guidelines: Risk-Enhancers for ASCVD

- Family history of premature ASCVD
- Persistently elevated LDL-C ≥ 160 mg/dL
- Chronic kidney disease
- Metabolic syndrome
- **Conditions specific to women (e.g., gestational diabetes, preeclampsia, premature menopause, post-menopausal state)**
- Inflammatory disease (generally **more common in women**)
- Ethnicity (e.g., South-Asian ancestry)

After Grundy, SM, et al. Circulation. 2019;139:e1082-e1143.

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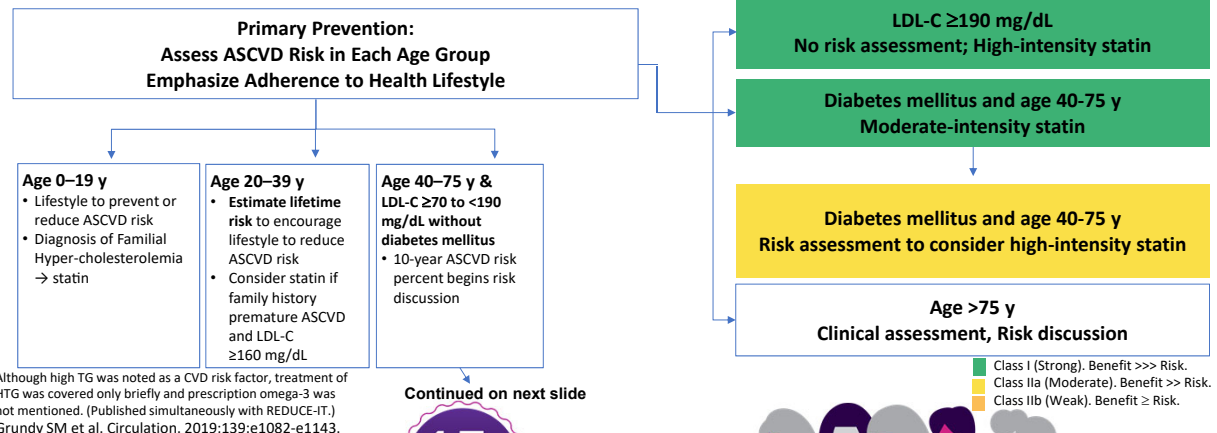


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2018 AHA/ACC Guideline on the Management of Blood Cholesterol: Primary Prevention



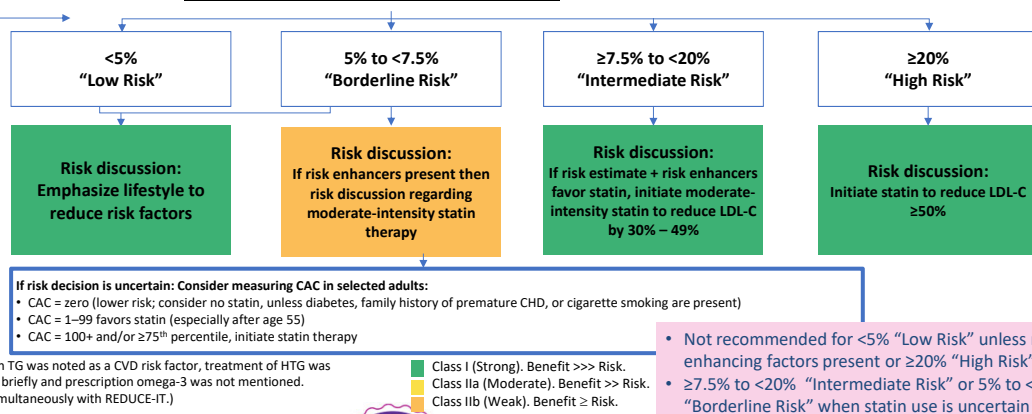
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2018 AHA/ACC Guideline on the Management of Blood Cholesterol: Primary Prevention (con't)



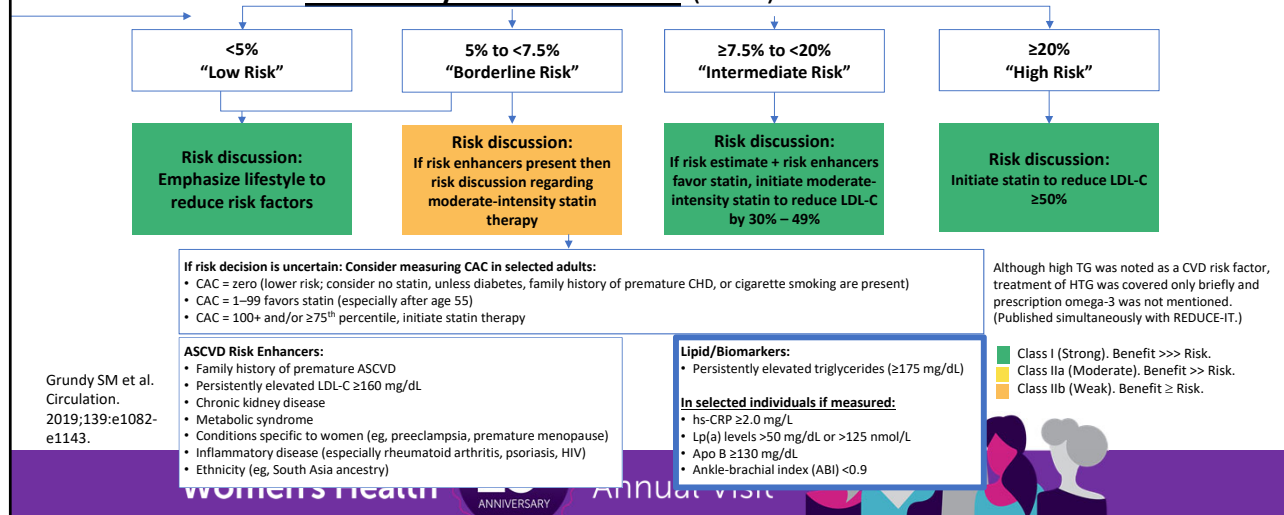
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2018 AHA/ACC Guideline on the Management of Blood Cholesterol: Primary Prevention (con't)



13

Very High Risk of Future CVD Events

Major ASCVD Events
Recent ACS (within the past 12 mo)
History of MI (other than recent ACS event listed above)
History of ischemic stroke
Symptomatic peripheral arterial disease (history of claudication with ABI <0.85, or previous revascularization or amputation [S4.1-39])
High-Risk Conditions
Age ≥65 y
Heterozygous familial hypercholesterolemia
History of prior coronary artery bypass surgery or percutaneous coronary intervention outside of the major ASCVD event(s)
Diabetes mellitus
Hypertension
CKD (eGFR 15-59 mL/min/1.73 m ²) (S4.1-15, S4.1-17)
Current smoking
Persistently elevated LDL-C (LDL-C ≥100 mg/dL [≥2.6 mmol/L]) despite maximally tolerated statin therapy and ezetimibe
History of congestive HF

Grundys SM et al. Circulation. 2019;139:e1082-e1143.

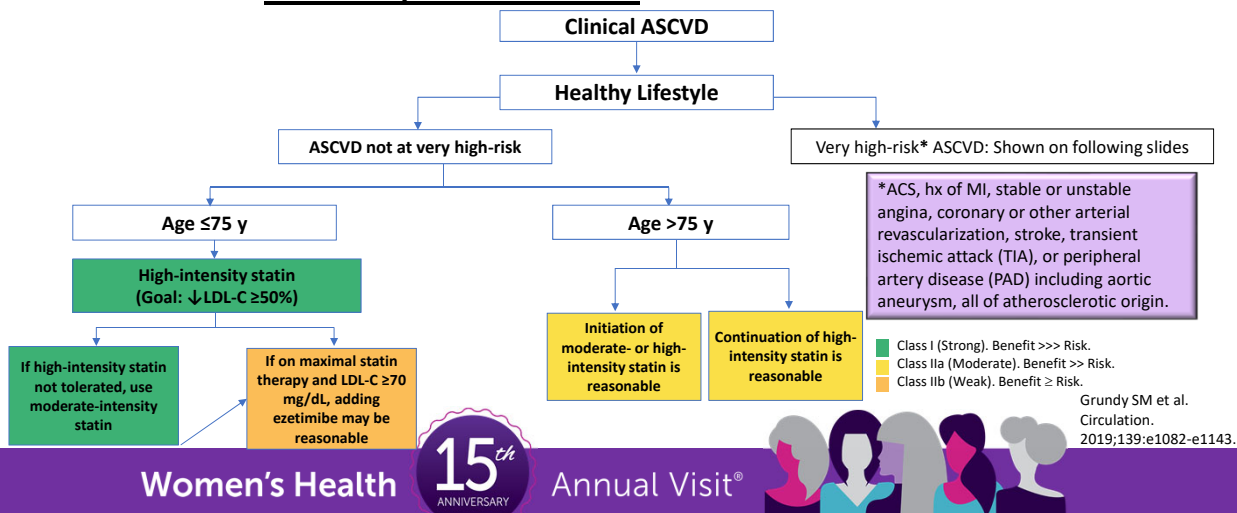
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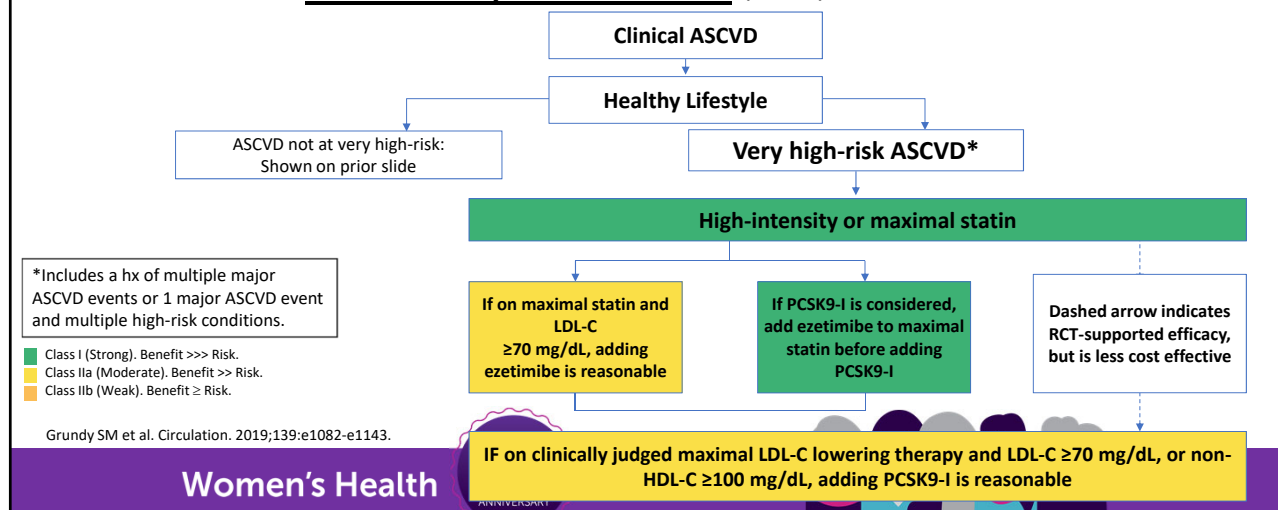
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2018 AHA/ACC Guideline on the Management of Blood Cholesterol: Primary Prevention



15

2018 AHA/ACC Guideline on the Management of Blood Cholesterol: Secondary Prevention (con't)



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New Guideline and Evidence to Improve Management of Patients with or at High-Risk of Atherosclerotic Cardiovascular Disease (ASCVD)

Hypertriglyceridemia (HTG)

Recommendations for HTG		
COR	LOE	Recommendations
I	B-NR	In adults 20 years of age or older with moderate HTG (fasting or nonfasting triglycerides 175 to 499 mg/dL [1.9 to 5.6 mmol/L]), clinicians should address and treat lifestyle factors (obesity and metabolic syndrome), secondary factors (diabetes mellitus, chronic liver or kidney disease and/or nephrotic syndrome, hypothyroidism), and medications that increase triglycerides.
Ila	B-R	In adults 40 to 75 years of age with moderate or severe HTG and ASCVD risk of 7.5% or higher, it is reasonable to reevaluate ASCVD risk after lifestyle and secondary factors are addressed and to consider a persistently elevated triglyceride level as a factor favoring initiation or intensification of statin therapy (see Section 4.4.2.).

Grundy SM et al. Circulation. 2019;139:e1082-e1143.

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Hypertriglyceridemia (HTG)

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Major Secondary Causes of HTG

- Diabetes Mellitus, Insulin Resistance
- Obesity
- Alcohol
- Chronic Kidney Disease
- Nephrotic syndrome
- Hypothyroidism
- HIV
- Hepatocellular disease
- Inflammatory diseases
- Chylomicronemia

After Bays HE. In: Kwiterovich PO Jr, ed. The Johns Hopkins Textbook of Dyslipidemia. 1st ed. Lippincott Williams & Wilkins;2010:245-57.

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Medications that Can Cause HTG

Agents Which Often Have Clinically-Relevant Effects

- Oral estrogens (effects vary by unclear patient-specific factors)
- Antiretroviral HIV regimens
- Phenothiazines – (2nd generation)
- Glucocorticoids (systemic only, not topical creams or nasal)
- Immunosuppressants
- Tamoxifen
- Isotretinoin
- Ethanol

Agents Which Rarely Have Clinically-Relevant Effects

- Bile-acid sequestrants
- Nonselective beta-blockers
- Diuretics

After Bays HE. In: Kwiterovich PO Jr, ed. The Johns Hopkins Textbook of Dyslipidemia. 1st ed. Lippincott Williams & Wilkins;2010:245-57.

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ACC/AHA 2018 Cholesterol Guidelines — Top 10 Take Home Messages

1. In all individuals, emphasize a heart-healthy lifestyle across the life course.

A healthy lifestyle reduces atherosclerotic cardiovascular disease (ASCVD) risk at all ages. In younger individuals, healthy lifestyle can reduce development of risk factors and is the foundation of ASCVD risk reduction.

In young adults 20 to 39 years of age, an assessment of lifetime risk facilitates the clinician–patient risk discussion (see No. 6) and emphasizes intensive lifestyle efforts. In all age groups, lifestyle therapy is the primary intervention for metabolic syndrome.

Grundy SM et al. Circulation. 2019;139:e1082-e1143.

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Nutrition Lifestyle Recommendations: Lipids and BP



- **Dietary patterns emphasis-based:**
 - DASH and Mediterranean-style eating plans
- Fruits, vegetables, and whole grains
- 30-35% fat intake
 - <6% saturated fats, no trans fats
- Low sodium (<2400 mg/day), high potassium
- Cut down on “processed” (dietary fiber removed/sugar added) or pre-prepared food
- Healthy eating for a lifetime



After Eckel RH et al. Circulation 2014;129 (25 Suppl 2):S76-99.

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Physical Activity Guidelines: Lipids and BP



- Advise adults to engage in aerobic physical activity
 - 3 to 4 sessions a week
 - lasting on average 40 min per session
 - involving moderate-to-vigorous intensity physical activity

Eckel RH et al. Circulation 2014;129 (25 Suppl 2):S76-99.

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ACC/AHA 2018 Cholesterol Guidelines — Top 10 Take Home Messages

2. In patients with clinical ASCVD, reduce low-density lipoprotein cholesterol (LDL-C) with high-intensity statin therapy or maximally tolerated statin therapy.

The more LDL-C is reduced on statin therapy, the greater will be subsequent risk reduction.

Use a maximally-tolerated statin to lower LDL-C levels by $\geq 50\%$.

Grundey SM et al. Circulation. 2019;139:e1082-e1143.

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ACC/AHA 2018 Cholesterol Guidelines — Top 10 Take Home Messages

3. In very-high-risk ASCVD, use an LDL-C threshold of 70 mg/dL to consider addition of nonstatins to statin therapy.

- Very high risk includes a history of multiple major ASCVD events or 1 major ASCVD event and multiple high-risk conditions.
- In very high-risk ASCVD patients, it is reasonable to add ezetimibe to maximally tolerated statin therapy when the LDL-C level remains ≥ 70 mg/dL.
- In patients at very high risk whose LDL-C level remains ≥ 70 mg/dL on maximally tolerated statin and ezetimibe therapy, adding a PCSK9 inhibitor is reasonable, although the long-term safety (>3 years) is uncertain and cost-effectiveness is low at mid-2018 list prices.

Grundy SM et al. Circulation. 2019;139:e1082-e1143.

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ACC/AHA 2018 Cholesterol Guidelines — Top 10 Take Home Messages

4. In patients with severe primary hypercholesterolemia (LDL-C level ≥ 190 mg/dL) without calculating 10-year ASCVD risk, begin high-intensity statin therapy without calculating 10-year ASCVD risk.

- If the LDL-C level remains ≥ 100 mg/dL, adding ezetimibe is reasonable
- If the LDL-C level on statin plus ezetimibe remains ≥ 100 mg/dL & the patient has multiple factors that increase subsequent risk of ASCVD events, PCSK9 inhibitor may be considered.

Grundy SM et al. Circulation. 2019;139:e1082-e1143.

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ACC/AHA 2018 Cholesterol Guidelines — Top 10 Take Home Messages

5. In patients 40 to 75 years of age with diabetes mellitus and LDL-C ≥ 70 mg/dL, start moderate-intensity statin therapy without calculating 10-year ASCVD risk.

In patients with diabetes mellitus at higher risk, especially those with multiple risk factors or those 50 to 75 years of age, it is reasonable to use a high-intensity statin to reduce the LDL-C level by $\geq 50\%$.

Grundy SM et al. Circulation. 2019;139:e1082-e1143.

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ACC/AHA 2018 Cholesterol Guidelines — Top 10 Take Home Messages

6. In adults 40 to 75 years of age evaluated for primary ASCVD prevention, have a clinician–patient risk discussion before starting statin therapy.

Risk discussion should include a review of:

- major risk factors (e.g., cigarette smoking, elevated blood pressure, LDL-C, hemoglobin A1C [if indicated], and calculated 10-year risk of ASCVD);
- the presence of risk-enhancing factors (see No. 8);
- the potential benefits of lifestyle and statin therapies;
- the potential for adverse effects and drug–drug interactions;
- the consideration of costs of statin therapy; and
- the patient preferences & values in shared decision-making.

Grundy SM et al. Circulation. 2019;139:e1082-e1143.

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ACC/AHA 2018 Cholesterol Guidelines — Top 10 Take Home Messages

7. In adults 40 to 75 years of age without diabetes mellitus and with LDL-C levels ≥ 70 mg/dL, at a 10-year ASCVD risk of $\geq 7.5\%$, start a moderate-intensity statin if a discussion of treatment options favors statin therapy.

Risk-enhancing factors favor statin therapy (see No. 8).

If risk status is uncertain, consider using coronary artery calcium (CAC) to improve specificity (see No. 9). If statins are indicated, reduce LDL-C levels by $\geq 30\%$, and if 10-year risk is $\geq 20\%$, reduce LDL-C levels by $\geq 50\%$.

Grundy SM et al. Circulation. 2019;139:e1082-e1143.

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ACC/AHA 2018 Cholesterol Guidelines — Top 10 Take Home Messages

8. In adults 40 to 75 years of age without diabetes mellitus and 10-year risk of 7.5% to 19.9% (intermediate risk), risk-enhancing factors favor initiation of statin therapy (see No. 7).

Risk-enhancing factors include family history of premature ASCVD; persistently elevated LDL-C levels ≥ 160 mg/dL; metabolic syndrome; chronic kidney disease; history of preeclampsia or premature menopause (age < 40 years); chronic inflammatory disorders (e.g., rheumatoid arthritis, psoriasis, or chronic HIV); high-risk ethnic groups (e.g., South Asian); persistent elevations of triglycerides ≥ 175 mg/dL; and, if measured in selected individuals

- apolipoprotein B ≥ 130 mg/dL;
- high-sensitivity C-reactive protein ≥ 2.0 mg/L;
- ankle-brachial index < 0.9 and Lp(a) ≥ 50 mg/dL, especially at higher values of Lp(a).

Risk-enhancing factors may favor statin therapy in patients at 10-year risk of 5-7.5% (borderline risk)

Grundy SM et al. Circulation. 2019;139:e1082-e1143.

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ACC/AHA 2018 Cholesterol Guidelines — Top 10 Take Home Messages

9. In adults 40 to 75 years of age without diabetes mellitus and with LDL-C levels ≥ 70 mg/dL — 189 mg/dL, at a 10-year ASCVD risk of $\geq 7.5\%$ to 19.9%, if a decision about statin therapy is uncertain, consider measuring CAC.

- If CAC is zero, treatment with statin therapy may be withheld or delayed, except in cigarette smokers, those with diabetes mellitus, and those with a strong family history of premature ASCVD.
- A CAC score of 1 to 99 favors statin therapy, especially in those ≥ 55 years of age.
- For any patient, if the CAC score is ≥ 100 Agatston units or ≥ 75 th percentile, statin therapy is indicated unless otherwise deferred by the outcome of clinician-patient risk discussion.

Grundy SM et al. Circulation. 2019;139:e1082-e1143.

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ACC/AHA 2018 Cholesterol Guidelines — Top 10 Take Home Messages

10. Assess adherence and percentage response to LDL-C-lowering medications and lifestyle changes with repeat lipid measurement 4 to 12 weeks after statin initiation or dose adjustment, repeated every 3 to 12 months as needed.

- Define responses to lifestyle and statin therapy by percentage reductions in LDL-C levels compared with baseline.
- In ASCVD patients at very high-risk, triggers for adding nonstatin drug therapy are defined by threshold LDL-C levels ≥ 70 mg/dL (≥ 1.8 mmol/L) on maximal statin therapy (see No. 3).

Grundy SM et al. Circulation. 2019;139:e1082-e1143.

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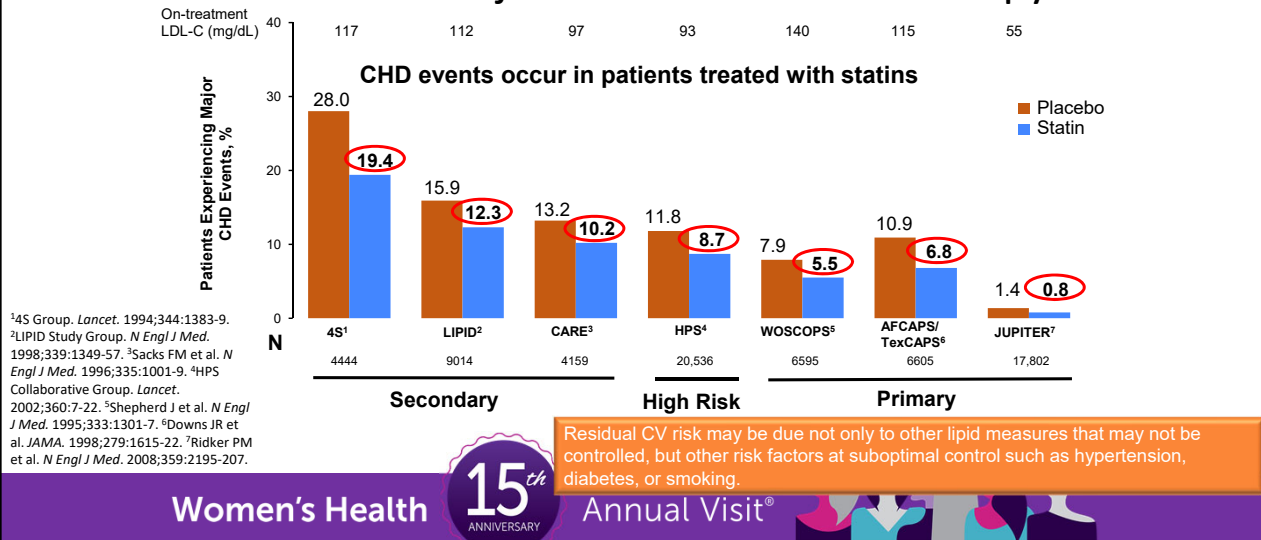


33

Commercial Interest Speakers Bureau: Amarin, Amgen, Boehringer, Kowa, Merck, Novo Nordisk, Regeneron, Sanofi

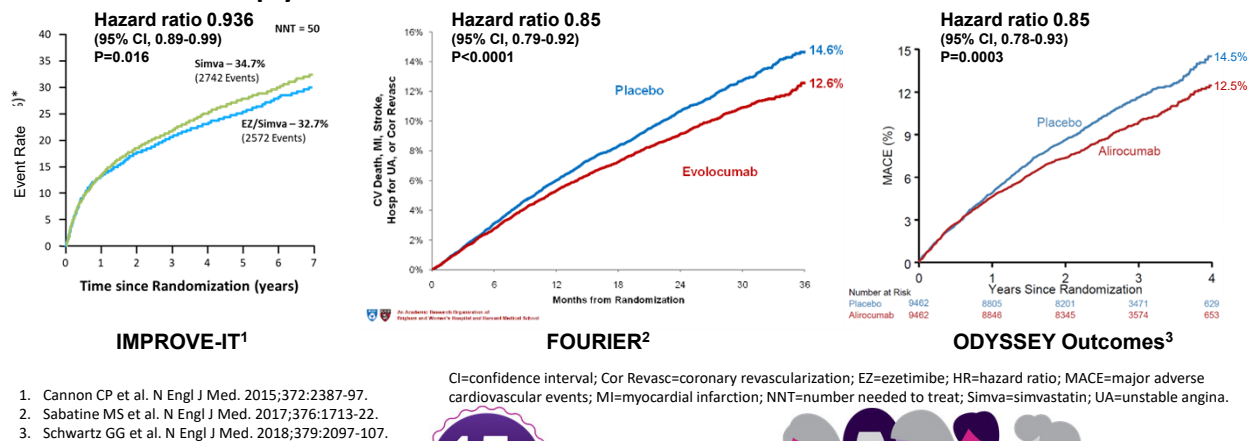


Residual CV Risk in Subjects on Statin Monotherapy



35

Additional LDL-C Lowering in Subjects on Statin Monotherapy Reduces CV Risk



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Fenofibrate Outcome Trials

Study	CV Risk Profile	Statin Use	Daily Intervention	Median Baseline TG Level	Effect on TG Level	Primary Outcome	Primary Outcome Results
ACCORD (N=5518)	- T2DM 40-79 yrs w/CVD <i>or</i> 55-79 yrs w/ ≥ 2 CV risk factors	All pts: Open-label simvastatin (mean dose: 22 mg/d)	Fenofibrate	162 mg/dL	-26%	- Nonfatal MI or - Stroke - or - CV death (Mean f/u: 4.7 yrs)	HR=0.92* (95% CI, 0.79-1.08) - P=0.32 (NS)
FIELD (N=9795)	- T2DM 50-75 yrs	Added during study in 2547 pts (26%)	Fenofibrate	154 mg/dL	-30% (at 1 yr)	- Nonfatal MI or - CHD death Median f/u: 5 yrs	HR=0.89* (95% CI, 0.75-1.05) - P=0.16 (NS)

*Note that *post hoc* analysis for both studies found statistically significant benefit in the subgroup of patients with TG $\geq$ 204 mg/dL & HDL-C $\leq$ 34 mg/dL (Sacks FM et al. *N Engl J Med*. 2010;363:692-4).

ACCORD Study Group et al. *N Engl J Med*. 2010;362:1563-74.
Keech A et al. *Lancet*. 2005;366:1849-61.

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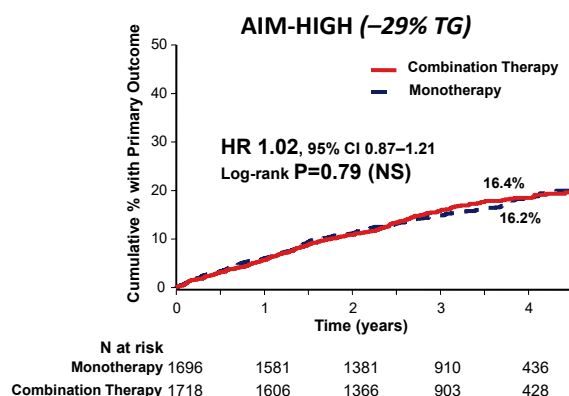
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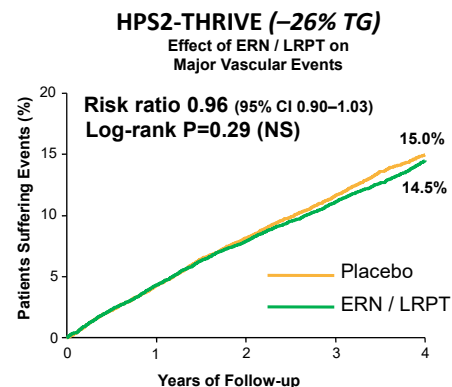


37

Niacin Outcome Trials



Boden WE et al. *N Engl J Med*. 2011;365:2255-67.
HPS2-THRIVE Collaborative Group. *N Engl J Med*. 2014;371:203-12.



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Low-Dose Omega-3 Mixtures Show No CV Benefit

Source	No. of Events (%)		Rate Ratios (CI)	Favors Treatment	Favors Control
	Treatment	Control			
Coronary heart disease					
Nonfatal myocardial infarction	1121 (2.9)	1155 (3.0)	0.97 (0.87–1.08)		
Coronary heart disease	1301 (3.3)	1394 (3.6)	0.93 (0.83–1.03)		
Any	3085 (7.9)	3188 (8.2)	0.96 (0.90–1.01)		
			P=.12		
Stroke					
Ischemic	574 (1.9)	554 (1.8)	1.03 (0.88–1.21)		
Hemorrhagic	117 (0.4)	109 (0.4)	1.07 (0.76–1.51)		
Unclassified/other	142 (0.4)	135 (0.3)	1.05 (0.77–1.43)		
Any	870 (2.2)	843 (2.2)	1.03 (0.93–1.13)		
			P=.60		
Revascularization					
Coronary	3044 (9.3)	3040 (9.3)	1.00 (0.93–1.07)		
Noncoronary	305 (2.7)	330 (2.9)	0.92 (0.75–1.13)		
Any	3290 (10.0)	3313 (10.2)	0.99 (0.94–1.04)		
			P=.60		
Any major vascular event	5930 (15.2)	6071 (15.6)	0.97 (0.93–1.01)		
			P=.10		

Adapted with permission* from Aung T, et al. Associations of omega-3 fatty acid supplement use with cardiovascular disease risks: Meta-analysis of 10 trials involving 77917 individuals. *JAMA Cardiol.* 2018;3:225-234. [*<https://creativecommons.org/licenses/by-nc/4.0/>]

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How May EPA and DHA Differ Re: Anti-Atherosclerotic Mechanisms?

Pros of EPA

Fits between PL legs (in lipoprt & cells):

- More stable in PL mono/bilayer
- Longer/better antiox effect
- No ↑chol crystals (vs. ↑ w/ DHA)

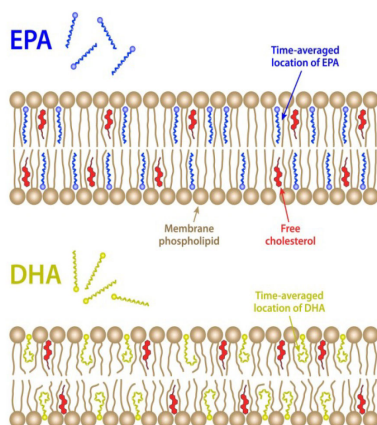
Fits in AA-series enzymes:

- ↓AA→pro-inflam cytokines
- ↓hsCRP
- No inhibition of LDL-R → modest ↓LDL-C/apoB

Pros of DHA

Coils up between PL legs:

- ↑↑Membrane fluidity
- Modest ↑HDL-C (vs. ↓ w/ EPA)



EPA and DHA Appear to be Similar Re:

- ↓TG
- Anti-platelet
- Anti/pro-arrhythmia

Bottom Line:

EPA may be better than DHA, but this is not yet proven clinically. More research is needed

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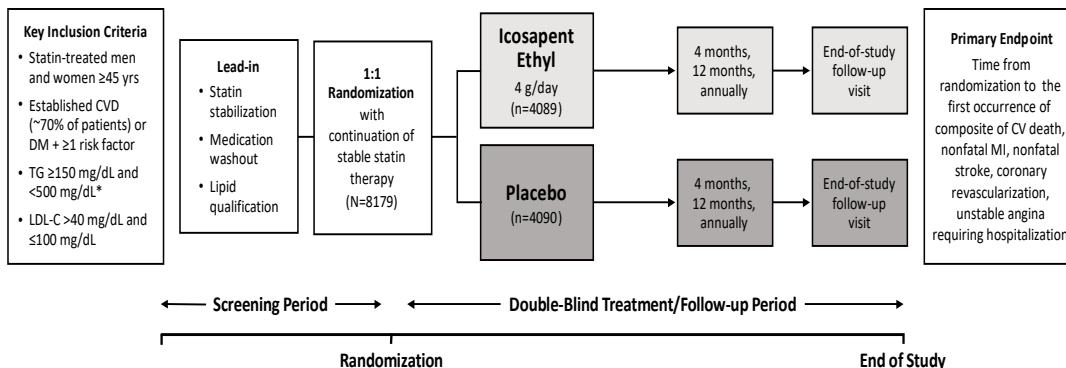
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REDUCE-IT Design



After Bhatt DL, Steg PG, Brinton EA, et al. Clin Cardiol. 2017;40:138-148.

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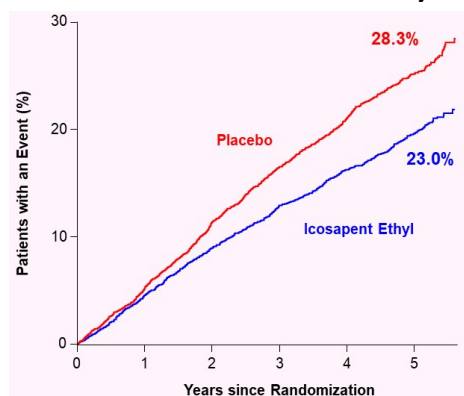
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41

Primary End Point: CV Death, MI, Stroke, Coronary Revasc, Unstable Angina



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.

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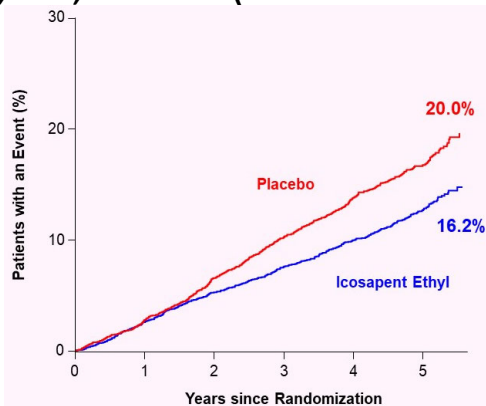
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42
New Guideline and Evidence to Improve Management
of Patients with or at High-Risk of Atherosclerotic
Cardiovascular Disease (ASCVD)

Key Secondary End Point: CV Death, MI, Stroke (“hard” CVD endpoints)



Hazard Ratio, 0.74

(95% CI, 0.65–0.83)

RRR = 26.5%

ARR = 3.6%

NNT = 28 (95% CI, 20–47)

P=0.0000006

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

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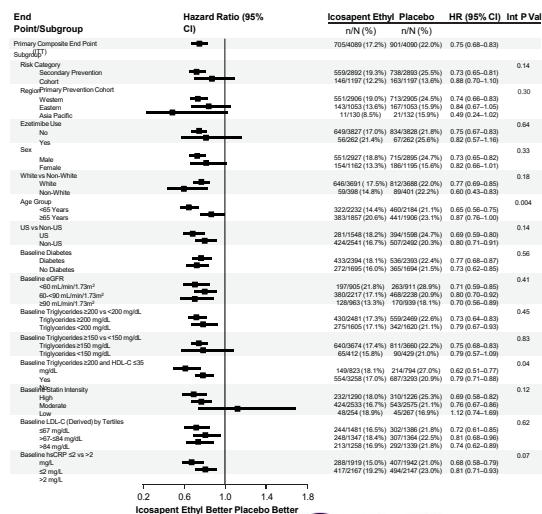
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43

Primary End Point in Subgroups



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

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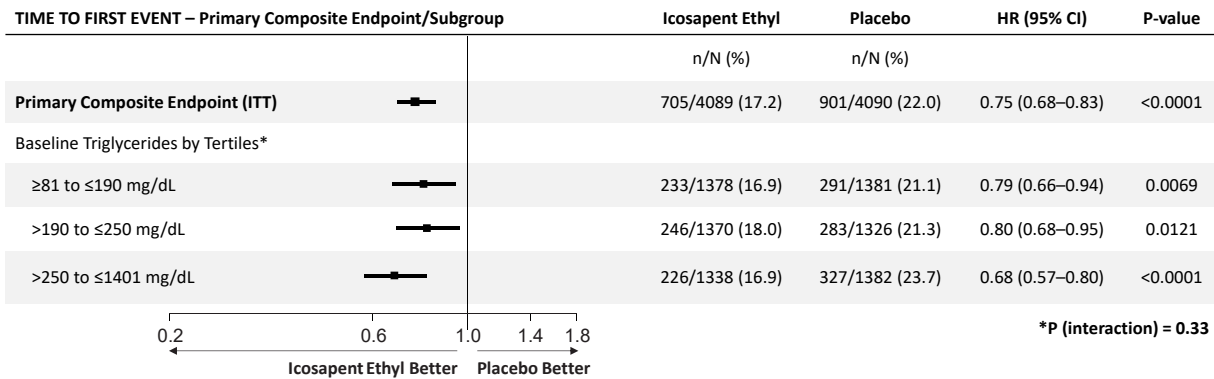
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44
New Guideline and Evidence to Improve Management
of Patients with or at High-Risk of Atherosclerotic
Cardiovascular Disease (ASCVD)

Primary Composite Endpoint: Time to First Event by Baseline TG Tertiles



Bhatt DL, Steg PG, Miller M, et al. J Am Coll Cardiol. 2019;74:1159-61.

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Treatment-Emergent Adverse Events

	Icosapent Ethyl (N=4089)	Placebo (N=4090)	P-value
Subjects with at Least One TEAE, n (%)	3343 (81.8%)	3326 (81.3%)	0.63
Serious TEAE	1252 (30.6%)	1254 (30.7%)	0.98
TEAE Leading to Withdrawal of Study Drug	321 (7.9%)	335 (8.2%)	0.60
Serious TEAE Leading to Withdrawal of Study Drug	88 (2.2%)	88 (2.2%)	1.00
Serious TEAE Leading to Death	94 (2.3%)	102 (2.5%)	0.61

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

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New Guideline and Evidence to Improve Management
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Cardiovascular Disease (ASCVD)

Treatment-Emergent Adverse Event of Interest: Serious Bleeding

	Icosapent Ethyl (N=4089)	Placebo (N=4090)	P-value
Bleeding related disorders	111 (2.7%)	85 (2.1%)	0.06
Gastrointestinal bleeding	62 (1.5%)	47 (1.1%)	0.15
Central nervous system bleeding	14 (0.3%)	10 (0.2%)	0.42
Other bleeding	41 (1.0%)	30 (0.7%)	0.19

- No fatal bleeding events in either group
- Adjudicated hemorrhagic stroke - no significant difference between treatments (13 icosapent ethyl versus 10 placebo; P=0.55)

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

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47

Adjudicated Events: Hospitalization for Atrial Fibrillation or Atrial Flutter

Primary System Organ Class Preferred Term	Icosapent Ethyl (N=4089)	Placebo (N=4090)	P-value
Positively Adjudicated Atrial Fibrillation/Flutter ^[1]	127 (3.1%)	84 (2.1%)	0.004

Note: Percentages are based on the number of subjects randomized to each treatment group in the Safety population (N).
All adverse events are coded using the Medical Dictionary for Regulatory Activities (MedDRA Version 20.1).

[1] Includes positively adjudicated Atrial Fibrillation/Flutter clinical events by the Clinical Endpoint Committee (CEC). P value was based on stratified log-rank test.

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

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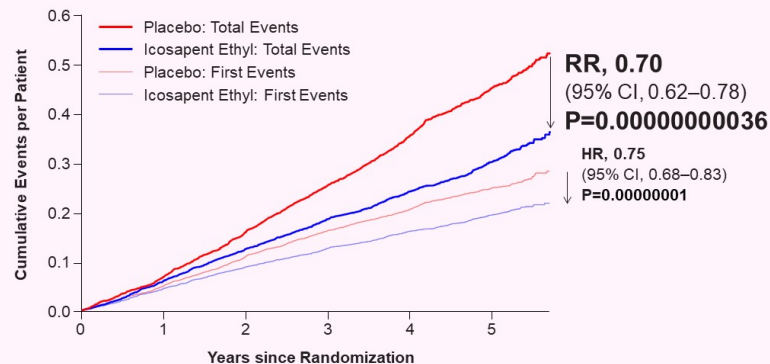


⁴⁸
New Guideline and Evidence to Improve Management
of Patients with or at High-Risk of Atherosclerotic
Cardiovascular Disease (ASCVD)

Total (First and Subsequent) Events

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

Primary Composite Endpoint



Bhatt DL, Steg PG, Miller M, et al. J Am Coll Cardiol. 2019;74:1159-61.

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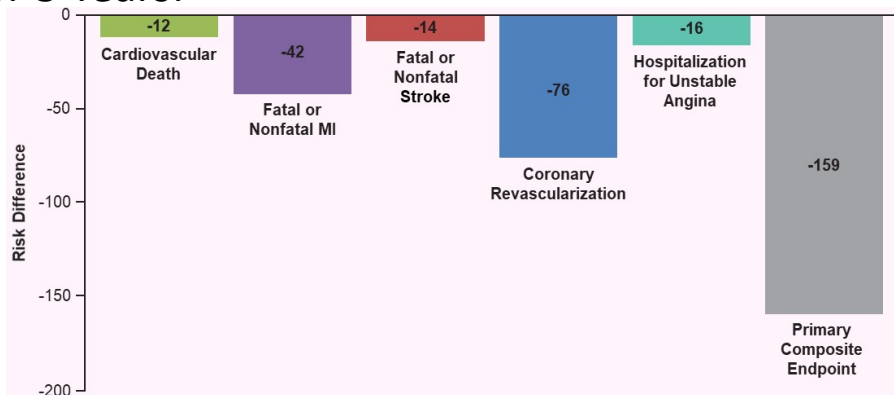
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49

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



Bhatt DL, Steg PG, Miller M, et al. J Am Coll Cardiol. 2019;74:1159-61.

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⁵⁰
New Guideline and Evidence to Improve Management of Patients with or at High-Risk of Atherosclerotic Cardiovascular Disease (ASCVD)

American Diabetes Association (ADA) Issues Updates to the 2019 Standards of Medical Care in Diabetes

Section 10 – Cardiovascular Disease and Risk Management: Lipid Management¹

- Treatment of Other Lipoprotein Fractions or Targets
 - In patients with ASCVD or other cardiac risk factors on a statin with controlled LDL-C, but elevated triglycerides (135-499), the addition of icosapent ethyl **should be considered** to reduce cardiovascular risk. **A**
 - “It should be noted that data are lacking with other omega-3 fatty acids, and results of the REDUCE-IT trial **should not be extrapolated to other products.**”
- Other Combination Therapy
 - Combination therapy (statin/fibrate) has not been shown to improve atherosclerotic cardiovascular disease outcomes and is generally **not recommended**. **A**
 - Combination therapy (statin/niacin) has not been shown to provide additional cardiovascular benefit above statin therapy alone, may increase the risk of stroke with additional side effects, and is generally **not recommended**. **A**

1. American Diabetes Association. 10. Cardiovascular disease and risk management: Standards of Medical Care in Diabetes—2019 [web annotation]. Diabetes Care 2019;42(Suppl.1):S103–S123. https://hyp.is/JHhz_ICrEmbF9LIVBZlw/care.diabetesjournals.org/content/42/Supplement_1/S103. Updated March 27, 2019. Accessed March 28, 2019.

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51

New Recommendations for Drug Treatment of Patients with Hypertriglyceridemia: European Society of Cardiology (ESC) and National Lipid Association (NLA)

Recommendations	Class ^a	Level ^b
Statin treatment is recommended as the first drug of choice to reduce CVD risk in high-risk individuals with hypertriglyceridaemia [TG levels >2.3 mmol/L (>200 mg/dL)]. ³⁵⁵	I	B
In high-risk (or above) patients with TG levels between 1.5–5.6 mmol/L (135–499 mg/dL) despite statin treatment, n-3 PUFAs (icosapent ethyl 2×2 g/day) should be considered in combination with a statin. ¹⁹⁴	IIa	B
In primary prevention patients who are at LDL-C goal with TG levels >2.3 mmol/L (>200 mg/dL), fenofibrate or bezafibrate may be considered in combination with statins. ^{305–307,356}	IIb	B
In high-risk patients who are at LDL-C goal with TG levels >2.3 mmol/L (>200 mg/dL), fenofibrate or bezafibrate may be considered in combination with statins. ^{305–307,356}	IIb	C

CVD = cardiovascular disease; LDL-C = low-density lipoprotein cholesterol; PUFA = polyunsaturated fatty acids; TG = triglyceride. a=Class of recommendation; b=Level of evidence.

NLA Position on the Use of Icosapent Ethyl in High and Very-high-risk Patients

- For patients 45 years of age or older with clinical ASCVD, or 50 years of age or older with type 2 diabetes requiring medication and ≥1 additional risk factor*, and fasting triglycerides 135-499 mg/dL on maximally tolerated statin, with or without ezetimibe, treatment with icosapent ethyl is recommended for ASCVD risk reduction. (I B-R)

CLASS I (STRONG)	Benefit >>> Risk
Suggested phrases for writing recommendations:	
• Is recommended	
• Is indicated/ useful/ effective/ beneficial	
LEVEL B-R	(Randomized)
• Moderate-quality evidence ^c from 1 or more RCTs	
• Meta-analyses of moderate-quality RCTs	

- * • Age: men ≥55 years and women ≥65 years
- Cigarette smoker or stopped smoking within 3 months
- Hypertension (≥140 mmHg systolic OR ≥90 mmHg diastolic) or on antihypertensive medication
- HDL-C ≤40 mg/dL for men or ≤50 mg/dL for women
- hs-CRP >3.0 mg/L
- Renal dysfunction: Creatinine clearance >30 and <60 mL/min
- Retinopathy
- Micro- or macro-albuminuria
- ABI <0.9 without symptoms of intermittent claudication

<https://www.lipid.org/nla/nla-position-use-icosapent-ethyl-high-and-very-high-risk-patients>

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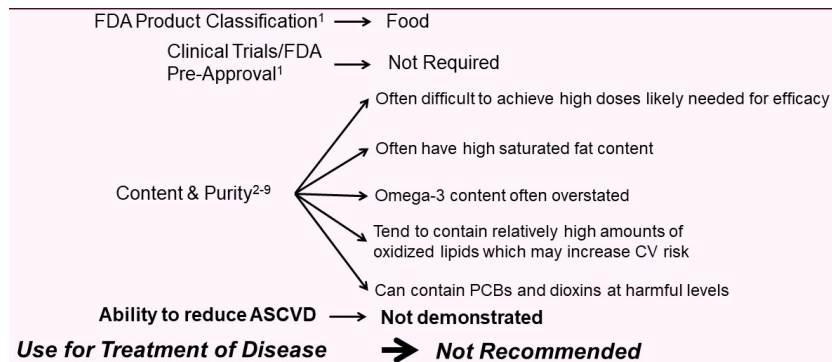


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⁵²
New Guideline and Evidence to Improve Management of Patients with or at High-Risk of Atherosclerotic Cardiovascular Disease (ASCVD)

Dietary Supplement Fish Oil: Not Useful for ASCVD Prevention



1. US Food and Drug Administration. www.fda.gov/Food/DietarySupplements/default.htm. Updated April 4, 2016. Accessed Nov. 4, 2018. 2. Hilleman D and Smer A. *Manag Care*. 2016;25:46-52. 3. Mason RP and Sherratt SCR. *Biochem Biophys Res Commun*. 2017;483:425-9. 4. Albert BB et al. *Sci Rep*. 2015;5:7928. 5. Kleiner AC et al. *J Sci Food Agric*. 2015;95:1260-7. 6. Ritter JC et al. *J Sci Food Agric*. 2013;93:1935-9. 7. Jackowski SA et al. *J Nutr Sci*. 2015;4:e30. 8. Rundblad A et al. *Br J Nutr*. 2017;117:1291-8. 9. European Medicines Agency, 2018: 712678.

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53

Besides the Other Issues with Dietary Supplements, You Need Huge Amounts to = 4g Rx EPA



Icosapent ethyl



EPA Dietary Supplement
(per label)



Krill oil
(per label)

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⁵⁴
New Guideline and Evidence to Improve Management
of Patients with or at High-Risk of Atherosclerotic
Cardiovascular Disease (ASCVD)

Conclusions

- Compared with placebo, icosapent ethyl 4g/day significantly reduced CV events — **time to first event**, primary endpoint—by **25%**, including:
 - 20% reduction in death due to cardiovascular causes
 - 31% reduction in heart attack
 - 28% reduction in stroke
- Low rate of adverse effects, including:
 - Small but significant increase in **atrial fibrillation**/flutter
 - Non-statistically significant increase in serious **bleeding**
- Consistent efficacy across multiple subgroups
 - Including baseline **TG 135-500 mg/dL**
 - Including **women** and secondary and primary prevention cohorts

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55

Conclusions

- Compared with placebo, icosapent ethyl 4g/day significantly reduced **total CV** events by **30%**, including:
 - 25% reduction in first cardiovascular events
 - 32% reduction in second cardiovascular events
 - 31% reduction in third cardiovascular events
 - 48% reduction in fourth or more cardiovascular events
- Analysis of first, recurrent, and total events demonstrates the large burden of ischemic events in statin-treated patients with baseline TG >~135 mg/dL and the potential role of icosapent ethyl in reducing this residual risk

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New Guideline and Evidence to Improve Management
of Patients with or at High-Risk of Atherosclerotic
Cardiovascular Disease (ASCVD)

Eliot A. Brinton, MD, FAHA, FNLA, FACE
Margo B. Minissian, PhD, ACNP



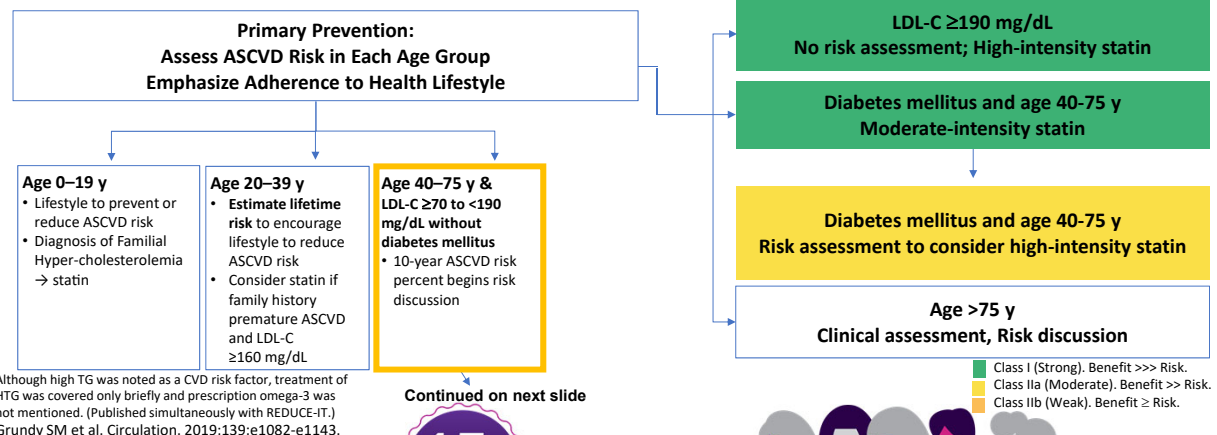
57

Fasting glucose	115 mg/dL
A1c	6.2%
TC	201 mg/dL
TG	320 mg/dL
HDL-C	38 mg/dL
LDL-C	98 mg/dL
Non-HDL-C	163 mg/dL



⁵⁸New Guideline and Evidence to Improve Management of Patients with or at High-Risk of Atherosclerotic Cardiovascular Disease (ASCVD)

2018 AHA/ACC Guideline on the Management of Blood Cholesterol: Primary Prevention



Although high TG was noted as a CVD risk factor, treatment of HTG was covered only briefly and prescription omega-3 was not mentioned. (Published simultaneously with REDUCE-IT.)
Grundy SM et al. Circulation. 2019;139:e1082-e1143.

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59

AMERICAN COLLEGE OF CARDIOLOGY ASCVD Risk Estimator Plus

7.7% Current 10-Year ASCVD RiskSM
Intermediate

Lifetime ASCVD Risk: **39%** Optimal ASCVD Risk: **2.7%**

Unit of Measure **US SI** [Reset All](#)

App should be used for primary prevention patients (those without ASCVD) only.

Current Age 59
Age must be between 20-79

Sex ☒ Male ☒ Female

Race ☐ White ☒ African American ☐ Other

Systolic Blood Pressure (mm Hg) 126
Value must be between 90-200

Diastolic Blood Pressure (mm Hg) 84
Value must be between 60-130

Total Cholesterol (mg/dL) 201
Value must be between 130-320

HDL Cholesterol (mg/dL) 38
Value must be between 20-100

LDL Cholesterol (mg/dL) 98
Value must be between 30-300

History of Diabetes? ☐ Yes ☒ No

Smoker? ☐ Current ☐ Former ☒ Never

On Hypertension Treatment? ☒ Yes ☐ No

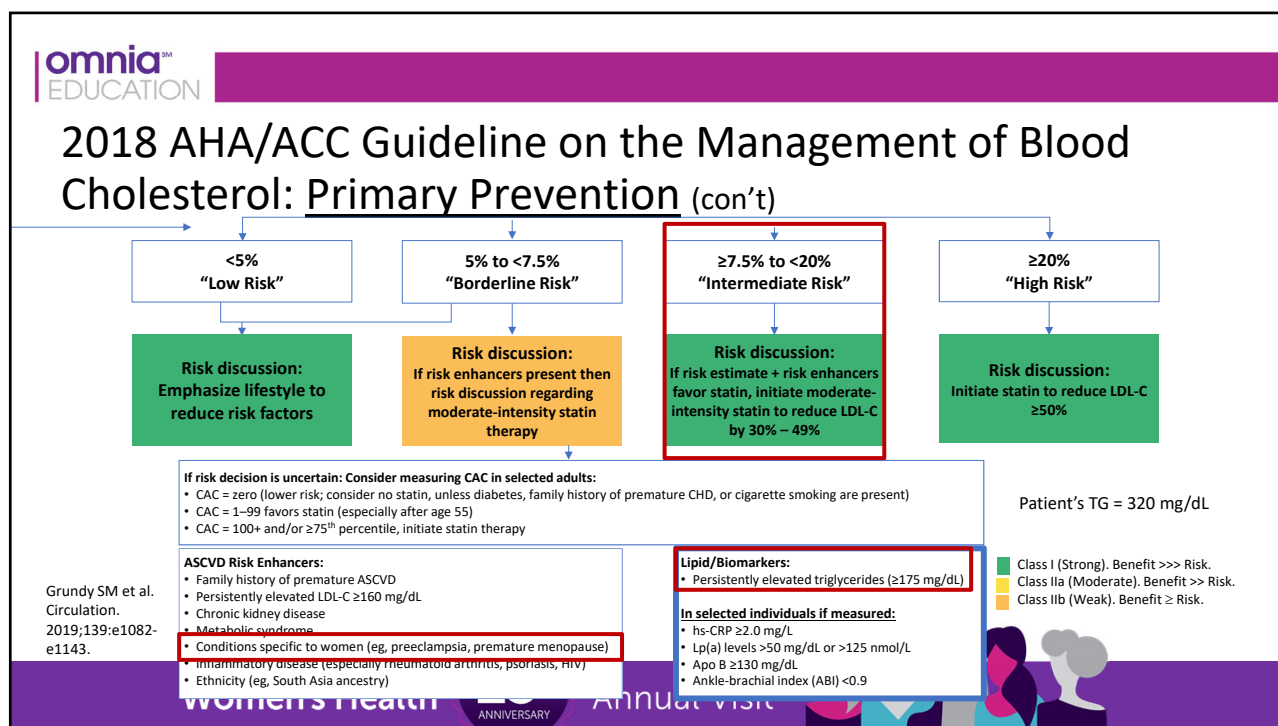
On a Statin? ☐ Yes ☒ No

On Aspirin Therapy? ☐ Yes ☒ No

Do you want to refine current risk estimation using data from a previous visit? ☐ Yes ☒ No

<http://tools.acc.org/ASCVD-Risk-Estimator-Plus/#/calculate/estimate/>

60
New Guideline and Evidence to Improve Management of Patients with or at High-Risk of Atherosclerotic Cardiovascular Disease (ASCVD)

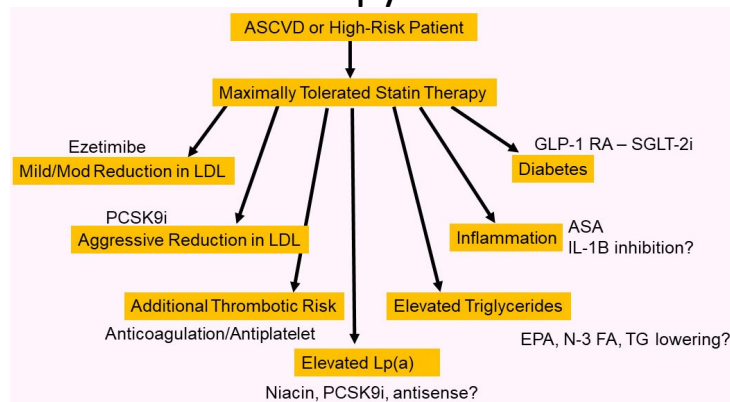


61



⁶²
New Guideline and Evidence to Improve Management of Patients with or at High-Risk of Atherosclerotic Cardiovascular Disease (ASCVD)

Pharmacologic Approaches to Managing Residual ASCVD Risk After Statin Therapy



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63