

EAS



# Raggiungimento dei goal terapeutici nei pazienti ipercolesterolemici: criticità e benefici

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|---------------------|----------------------------|-----------------------------------|------------------------|--------------------------|----------------------|-----------------------------------|-----------------|-------------------------------|
| Alfasigma           | X                          |                                   |                        |                          |                      |                                   |                 |                               |
| Amgen               | X                          |                                   |                        |                          |                      |                                   |                 |                               |
| Eli Lilly           | X                          |                                   |                        |                          |                      |                                   |                 |                               |
| AKCEA               |                            | X                                 |                        |                          |                      |                                   |                 |                               |
| Abbott - Mylan      | X                          | X                                 |                        |                          |                      |                                   |                 |                               |
| Servier             | X                          |                                   |                        |                          |                      |                                   |                 |                               |
| Sanofi              | X                          |                                   |                        |                          |                      |                                   |                 |                               |
| Amarin              | X                          | X                                 |                        |                          |                      |                                   |                 |                               |
| Novartis            |                            | X                                 |                        |                          |                      |                                   |                 |                               |

# Raggiungimento dei goal terapeutici nei pazienti ipercolesterolemici: criticità e benefici

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## ➤ **CRITICITA'**

### ➤ **NUOVI OBIETTIVI DI LDL-C: UNA SFIDA TERAPEUTICA**

### ➤ **STRATEGIE ATTUALI PER RAGGIUNGERE GLI OBIETTIVI DI LDL-C:**

- ✓ **APPROCCIO A STEP TERAPEUTICI SEQUENZIALI**
- ✓ **USO IN PRIMA BATTUTA DELLA TERAPIA DI ASSOCIAZIONE**
- ✓ **ADERENZA TERAPEUTICA**

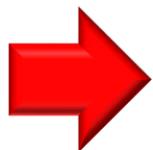
## ➤ **BENEFICI:**

- ✓ **RAGGIUNGIMENTO DEL GOAL TERAPEUTICO DI LDL-C ED EVENTI CV RISPARMIATI**
- ✓ **IMPORTANZA DI RIDURRE LDL-C IN MODO EFFICACE ED IL PRIMA POSSIBILE**

## ➤ **TAKE HOME MESSAGE**

## Recommended treatment goals for LDL-C Lowering therapy: 2016 vs 2019

| Risk category  | LDL goals (starting with untreated LDL-C)                                 |                                    |
|----------------|---|------------------------------------|
|                | 2016  | 2019                               |
| Very-high risk | <1.8 mmol/L (70 mg/dL) or >50% ↓ if LDL-C 1.8–3.5 mmol/L (70–135 mg/dL)   | <1.4 mmol/L (<55 mg/dL) and >50% ↓ |
| High-risk      | <2.6 mmol/L (100 mg/dL) or >50% ↓ if LDL-C 2.6–5.2 mmol/L (100–200 mg/dL) | <1.8 mmol/L (<70 mg/dL) and >50% ↓ |
| Moderate-risk  | <3.0 mmol/L (115 mg/dL)   | <2.6 mmol/L (<100 mg/dL)           |
| Low-risk       | <3.0 mmol/L (115 mg/dL)   | <3.0 mmol/L (<115 mg/dL)           |



For patients with ASCVD experiencing a **second vascular event within 2 years** while taking maximumly tolerated statin-based therapy, an **LDL-C goal of <1.0 mmol/L (<40 mg/dL)** is recommended

LDL-C = low-density lipoprotein cholesterol.

Adapted from: Catapano AL, et al. Eur Heart J 2016;37:2999-3058. Mach F, et al. Eur Heart J 2019. doi:10.1093/eurheartj/ehz455. Epub ahead of print.

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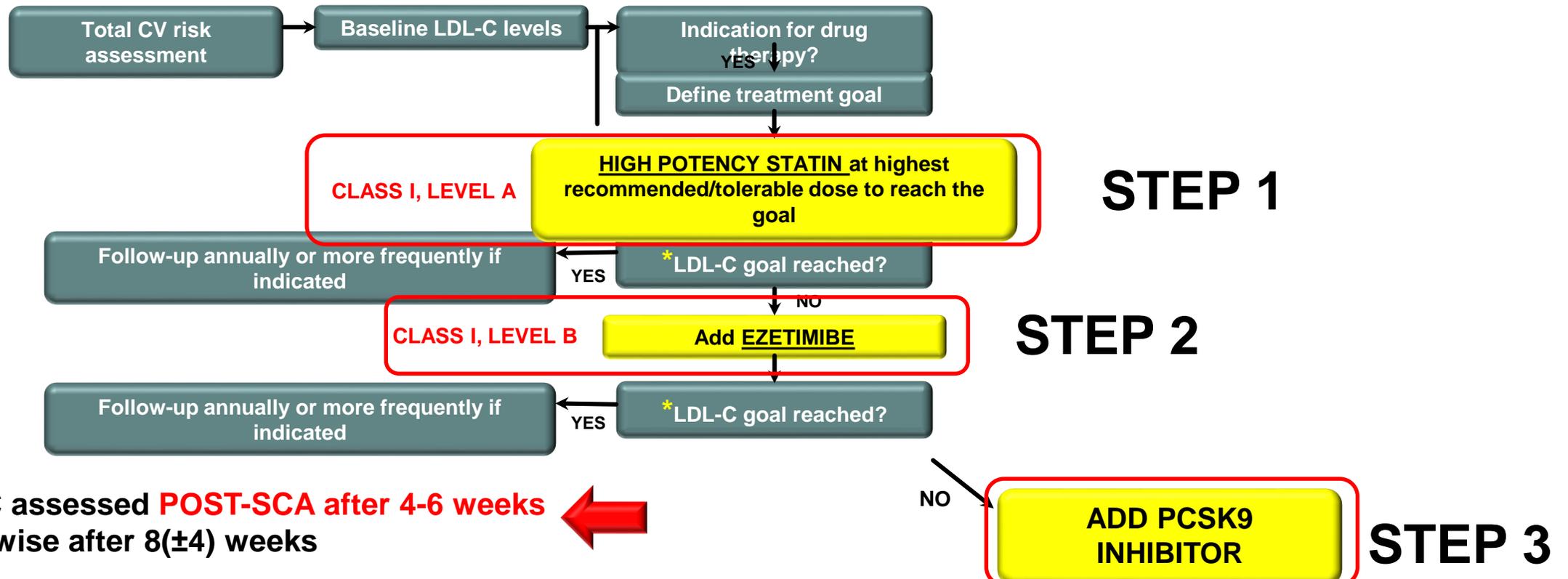
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## 2019 ESC/EAS GUIDELINES: TREATMENT ALGORITHM FOR PHARMACOLOGICAL LDL-C LOWERING



- LDL-C assessed **POST-SCA** after 4-6 weeks
- Otherwise after 8(±4) weeks

- Secondary prevention (also FH) (very high-risk) (CLASS IA)
- Primary prevention: patients with FH and another major risk factor (very high-risk) (CLASS IC)

CV = cardiovascular; FH = familial hypercholesterolaemia; LDL-C = low density lipoprotein-C; PCSK9 = proprotein convertase subtilisin/kexin type 9.

Adapted from: Mach F, et al. Eur Heart J 2019. doi:10.1093/eurheartj/ehz455. Epub ahead of print.

# No LLT optimization during FU

A cross-sectional ESC-EORP survey (EUROASPIRE V) at 131 centers in 81 regions in 27 countries including patients with coronary artery events or interventions

**Low rate of patients at (2016) target (<70 mg/dL): 32% men, 23% women**

Change in the LDL-C-lowering therapies from discharge to interview.

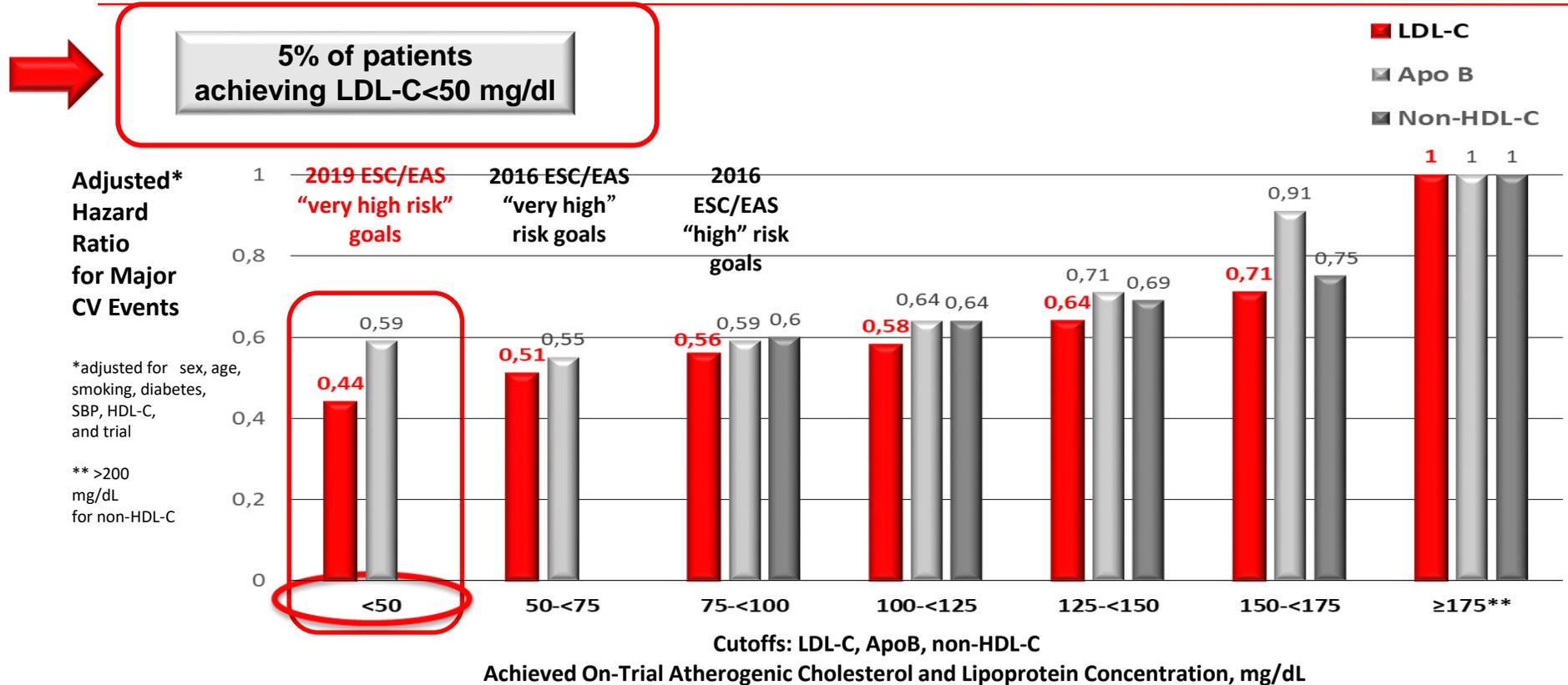
| Prescribed at hospital discharge | Used at the time of interview | % (n)            |
|----------------------------------|-------------------------------|------------------|
| No LLT                           | No LLT                        | 5.0 (374/7528)   |
| Low/Moderate intensity LLT       | Low/Moderate intensity LLT    | 20.2 (1521/7528) |
| High intensity LLT               | High intensity LLT            | 42.3 (3181/7528) |
| High intensity LLT               | Low/Moderate intensity LLT    | 10.0 (755/7528)  |
| High intensity LLT               | No LLT                        | 6.2 (463/7528)   |
| Low/moderate intensity LLT       | No LLT                        | 4.6 (350/7528)   |
| No LLT                           | Low/moderate intensity LLT    | 3.9 (297/7528)   |
| No LLT                           | High intensity LLT            | 3.2 (241/7528)   |
| Low/moderate intensity LLT       | High intensity LLT            | 4.6 (346/7528)   |

**At first prescription (discharge): 58,5%** are treated with **high intensity statins**.

- During FU, there is a **decrease** to low/moderate intensity (or no LLT) in **20,8%**
- During FU: there is an **increase in LLT** in **11.7%** during FU

**=> Instead of an increase, there is mostly a decrease in LLT intensity during FU**

# Meta-analysis of 8 Statin Trials (Moderate- to High-Intensity Dosing): Patients Who Achieved Very Low LDL-C Levels Had Lower Risk for Major Cardiovascular Events



Abbreviations: apo, apolipoprotein; CV, cerebrovascular; HDL-C, high-density lipoprotein cholesterol; LDL-C, low-density lipoprotein cholesterol.

Boekholdt SM, et al. *J Am Coll Cardiol.* 2014;64(5):485-494.



# 2019 ESC/EAS Guidelines for the management of dyslipidaemias: *lipid modification to reduce cardiovascular risk*



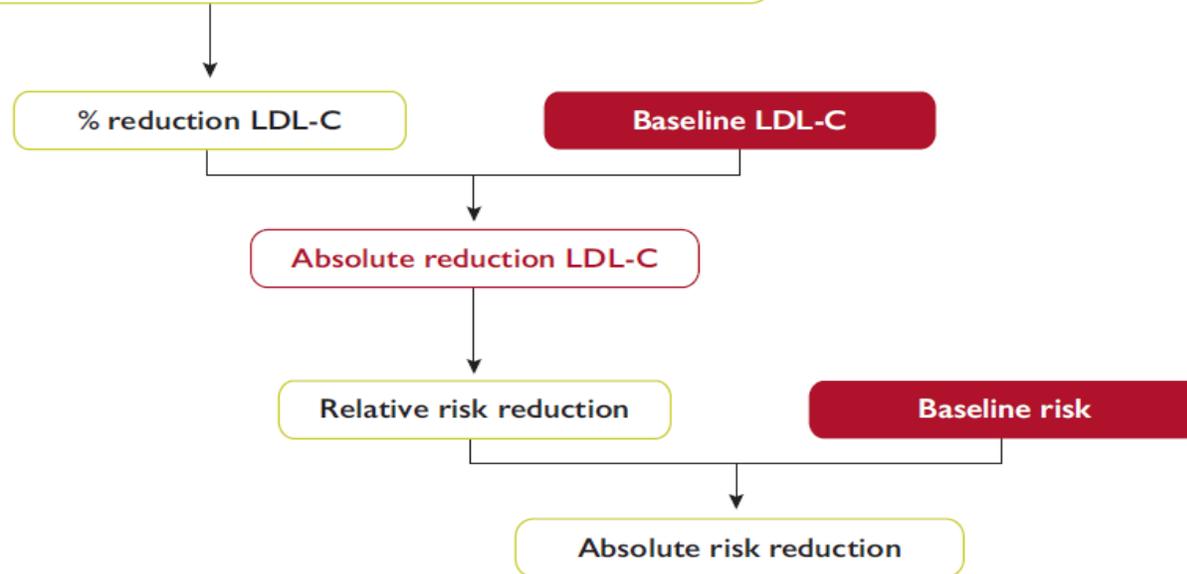
The Task Force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and European Atherosclerosis Society (EAS)

**STEP 2**

| 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%                   |

≈65%

**Expected clinical benefits of LDL-C lowering therapies**



# How many very high risk patients are treated in real practice with combination of high intensity statin and ezetimibe?



Contents lists available at [ScienceDirect](#)

**Atherosclerosis**

journal homepage: [www.elsevier.com/locate/atherosclerosis](http://www.elsevier.com/locate/atherosclerosis)

Management of dyslipidaemia in patients with coronary heart disease: Results from the ESC-EORP EUROASPIRE V survey in 27 countries

Check for updates

7824 patients,  $\geq 6$  months after hospitalization for a coronary event

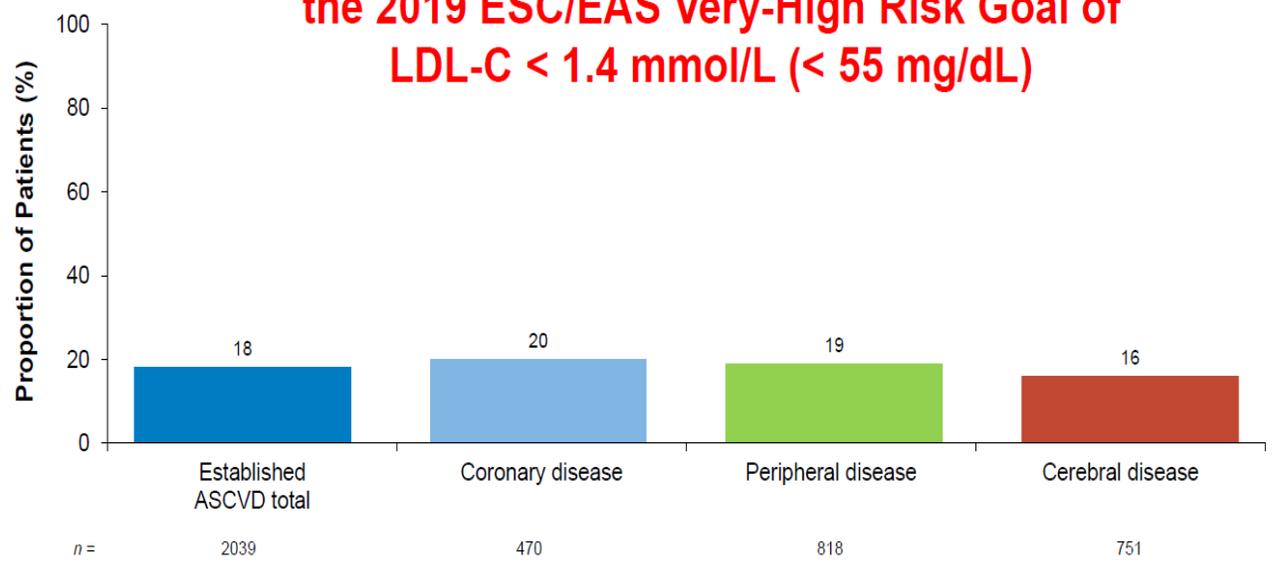
The combination of atorvastatin 40–80 mg/d or rosuvastatin 20–40 mg/d with ezetimibe 10 mg/d was reported by 211 patients (5.5% of all those on a high-intensity LLT and 2.7% of all patients); in them the LDL-C goal of  $< 1.8$  mmol/L (70 mg/dL) was achieved in 52%. (Vs 29% in total population)

# EU-Wide Cross-Sectional Observational Study of Lipid-Modifying Therapy Use in Secondary and Primary Care – the DA VINCI Study

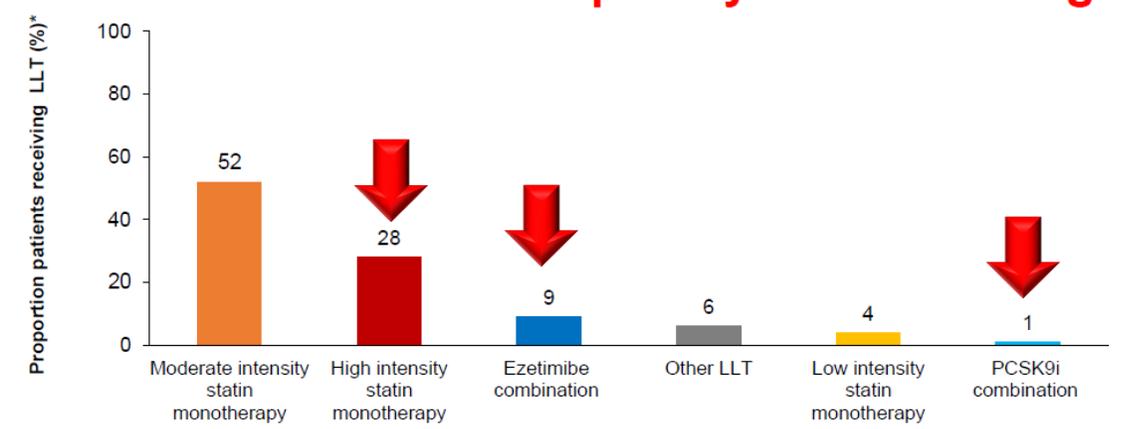
Kausik K Ray<sup>1</sup>, Bart Molemans<sup>2</sup>, W Marieke Schoonen<sup>3</sup>, Periklis Giovas<sup>4</sup>, Sarah Bray<sup>5</sup>, Gaia Kiru<sup>6</sup>, Jennifer Murphy<sup>6</sup>, Maciej Banach<sup>7,8,9</sup>, Stefano De Servi<sup>10</sup>, Dan Gaita<sup>11</sup>, Ioanna Gouni-Berthold<sup>12</sup>, G Kees Hovingh<sup>13</sup>, Jacek J Jozwiak<sup>14</sup>, J Wouter Jukema<sup>15</sup>, Robert Gabor Kiss<sup>16</sup>, Serge Kownator<sup>17</sup>, Helle K Iversen<sup>18,19</sup>, Vincent Maher<sup>20</sup>, Luis Masana<sup>21</sup>, Alexander Parkhomenko<sup>22</sup>, André Peeters<sup>23</sup>, Piers Clifford<sup>24</sup>, Katarina Raslova<sup>25</sup>, Peter Siostrzonek<sup>26</sup>, Stefano Romeo<sup>27,28,29</sup>, Dimitrios Tousoulis<sup>30</sup>, Charalambos Vlachopoulos<sup>30</sup>, Michal Vrablik<sup>31</sup> and Alberico L Catapano<sup>10,324,35</sup>, Neil R Poulter<sup>6</sup>; on behalf of the DA VINCI study\*

**Implementation of both 2016 and 2019 ESC/EAS guideline LDL-C goal attainment for patients (n=5888) across 18 countries in Europe in primary and secondary healthcare settings**

**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)**



**Overall, Moderate-Intensity Statin Monotherapy was the Most Frequently Used LLT Regimen**



**Only 28% of patients were receiving high intensity statin monotherapy  
Few patients (9%) were receiving ezetimibe combo  
Even fewer patients (1%) received PCSK9i combo**

# Statin utilization and lipid goal attainment in high or very-high cardiovascular risk patients: insights from Italian general practice

Use of lipid modifying therapy in 66.158 Italian patients at high/very high CV risk

|   | %    | Total cohort<br>n=66,158 | ASCVD<br>n=36,120   |                         |                   |                | DM alone<br>n=27,957 | HeFH<br>n=2,081 |
|---|------|--------------------------|---------------------|-------------------------|-------------------|----------------|----------------------|-----------------|
|   |      |                          | Recent ACS<br>n=736 | Chronic CHD<br>n=19,622 | Stroke<br>n=9,721 | PAD<br>n=6,041 |                      |                 |
| <b>High-Intensity statin</b>            | 7.7  |                          | 56.1                | 15.9                    | 5.5               | 3.6            | 2.4                  | 6.7             |
| Monotherapy                             | 96.7 |                          | 97.8                | 96.3                    | 97.9              | 95.8           | 97                   | 95.7            |
| <b>Plus ezetimibe</b>                   | 2.8  |                          | 1.9                 | 3.3                     | 1.7               | 1.9            | 2.4                  | 2.9             |
| Plus other non-statin LMT               | 0.5  |                          | 0.2                 | 0.4                     | 0.4               | 2.3            | 0.6                  | 1.4             |
| <b>Low-to-moderate intensity statin</b> | 43.3 |                          | 26.6                | 49.8                    | 49.4              | 36.7           | 37.5                 | 55.8            |
| Monotherapy                             | 93.1 |                          | 87.2                | 90.5                    | 94.4              | 95.3           | 95.3                 | 87.2            |
| <b>Plus ezetimibe</b>                   | 6.5  |                          | 12.2                | 9.3                     | 5.2               | 4.4            | 4.2                  | 12.7            |
| Plus other non-statin LMT               | 0.4  |                          | 0.5                 | 0.3                     | 0.3               | 0.3            | 0.5                  | 0.1             |
| <b>Nonstatin LMT only</b>               | 2.3  |                          | 1.9                 | 2.5                     | 2.2               | 1.6            | 2.5                  | 2.2             |
| Ezetimibe                               | 41.0 |                          | 92.9                | 58.5                    | 45.2              | 35.7           | 24.2                 | 91.3            |
| Other LMT                               | 59.0 |                          | 7.1                 | 41.5                    | 54.8              | 64.3           | 75.8                 | 8.7             |
| <b>Evidence or prior LMT</b>            | 18.3 |                          | 7.5                 | 17.4                    | 19.0              | 17.8           | 18.2                 | 28.1            |
| High-intensity statin                   | 11.8 |                          | 54.4                | 22.6                    | 7.5               | 7.2            | 6.0                  | 17.1            |
| Low-to-moderate intensity statin        | 83.4 |                          | 43.5                | 74.5                    | 89.4              | 88.3           | 86.4                 | 82.3            |
| Nonstatin in LMT                        | 4.9  |                          | 1.8                 | 2.8                     | 3.4               | 4.6            | 7.6                  | 0.6             |
| <b>No evidence of prior LMT</b>         | 28.4 |                          | 7.9                 | 14.5                    | 24.0              | 40.3           | 39.3                 | 7.2             |

# Raggiungimento dei goal terapeutici nei pazienti ipercolesterolemici: criticità e benefici

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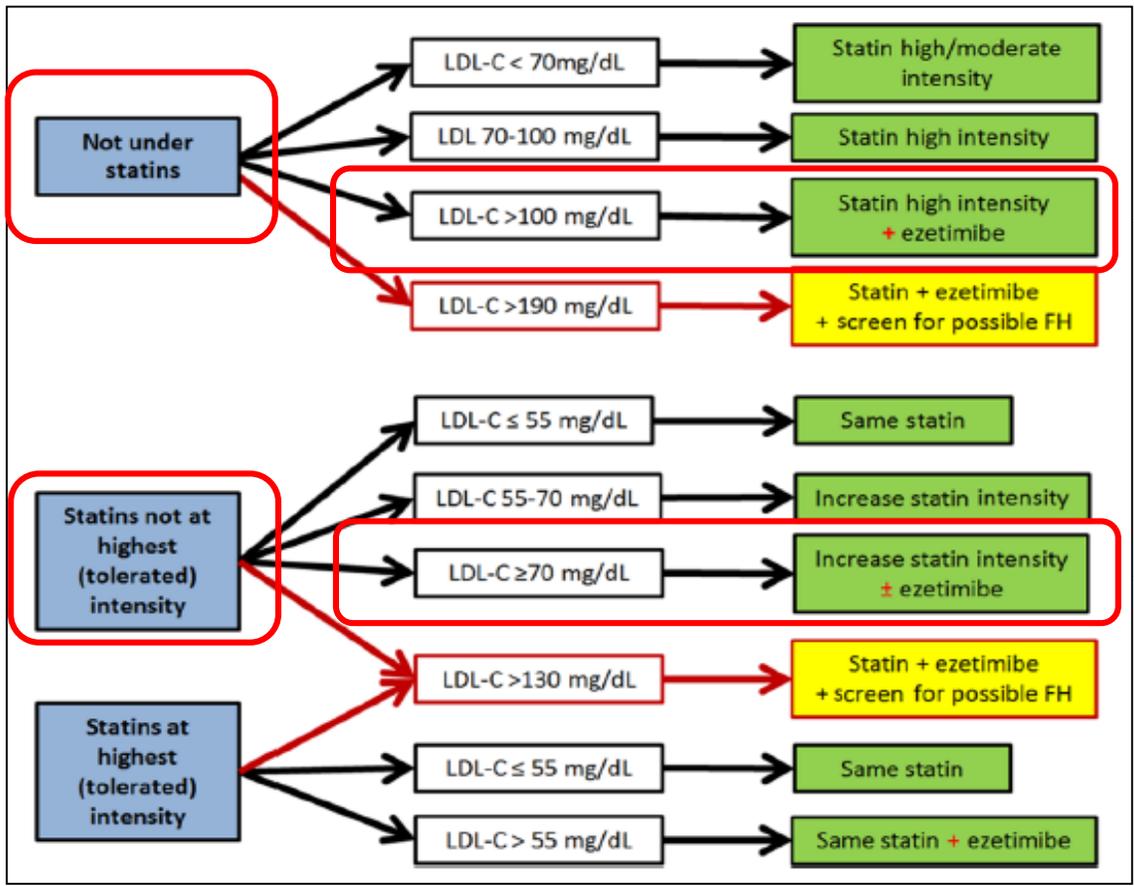
✓ APPROCCIO A STEP TERAPEUTICI SEQUENZIALI

✓ USO IN PRIMA BATTUTA DELLA TERAPIA DI ASSOCIAZIONE

# Combination of LLT: Stepwise vs Systematic Combination

**A consensus statement on lipid management after acute coronary syndrome**

**An innovative lipid-lowering approach to enhance attainment of low-density lipoprotein cholesterol goals**

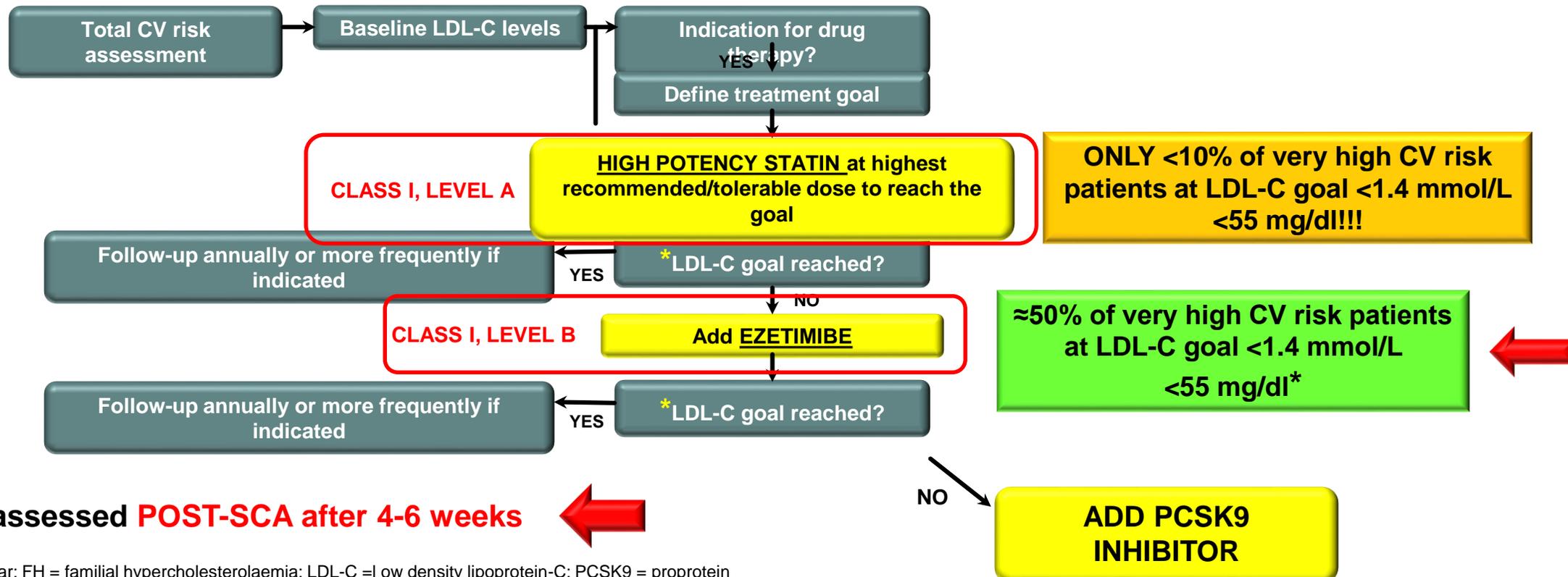


***Real-life application in 270 randomly selected Very High Risk patients***

- Admission LDL-c : 120±47 mg/dL (33% already under statins at admission).
- Compliance with algorithm = 76%
- Discharge: 97% high intensity statins, 67% ezetimibe

**AFTER 2 MONTHS**  
 • **LDL-C Target: 56% at ESC 2019 target**

## 2019 ESC/EAS GUIDELINES: TREATMENT ALGORITHM FOR PHARMACOLOGICAL LDL-C LOWERING



\* LDL-C assessed **POST-SCA** after 4-6 weeks

CV = cardiovascular; FH = familial hypercholesterolaemia; LDL-C = low density lipoprotein-C; PCSK9 = proprotein convertase subtilisin/kexin type 9.

Adapted from: Mach F, et al. Eur Heart J 2019. doi:10.1093/eurheartj/ehz455. Epub ahead of print.

- **Secondary prevention (also FH) (very high-risk) (CLASS IA)**
- **Primary prevention: patients with FH and another major risk factor (very high-risk) (CLASS IC)**



From the EAS

Practical guidance for combination lipid-modifying therapy in high- and very-high-risk patients: A statement from a European Atherosclerosis Society Task Force

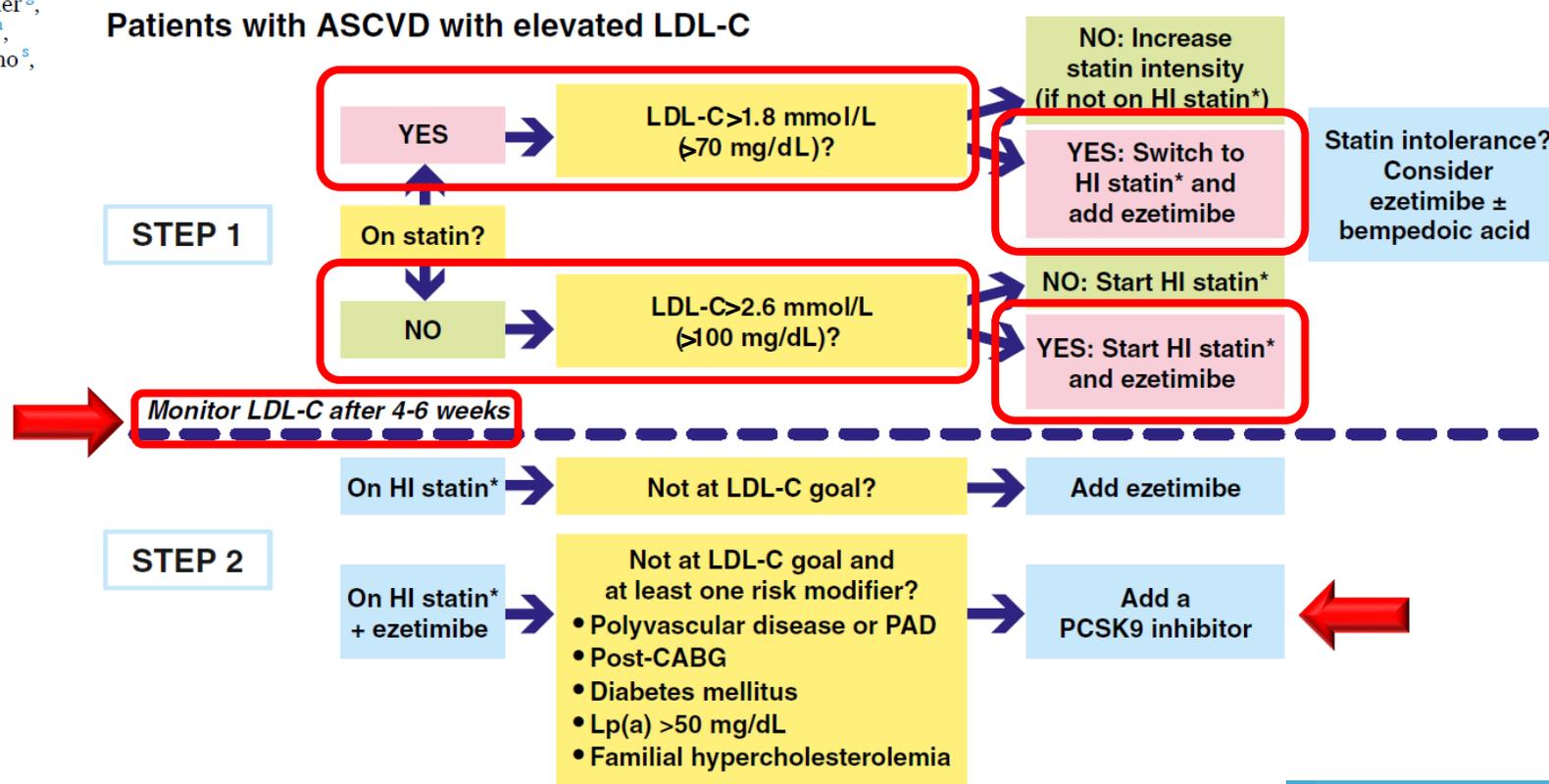
Maurizio Averna<sup>a</sup>, Maciej Banach<sup>b</sup>, Eric Bruckert<sup>c</sup>, Heinz Drexel<sup>d,e,f</sup>, Michel Farnier<sup>g</sup>, Dan Gaita<sup>h</sup>, Paolo Magni<sup>i</sup>, Winfried März<sup>j,k</sup>, Luis Masana<sup>l</sup>, Alberto Mello e Silva<sup>m</sup>, Zeljko Reiner<sup>n</sup>, Emilio Ros<sup>o,p</sup>, Michal Vrablik<sup>q</sup>, Alberto Zamboni<sup>r</sup>, Jose L. Zamorano<sup>s</sup>, Jane K. Stock<sup>t</sup>, Lale S. Tokgözoğlu<sup>u</sup>, Alberico L. Catapano<sup>b,\*</sup>

**RESULTS:** Statin-ezetimibe combination treatment is the first choice for managing elevated LDL-C and **should be given upfront in very-high-risk patients with high LDL-C** unlikely to reach goal with a statin, and in primary prevention familial hypercholesterolaemia patients.

## 2021 EAS

## TASK FORCE STATEMENT

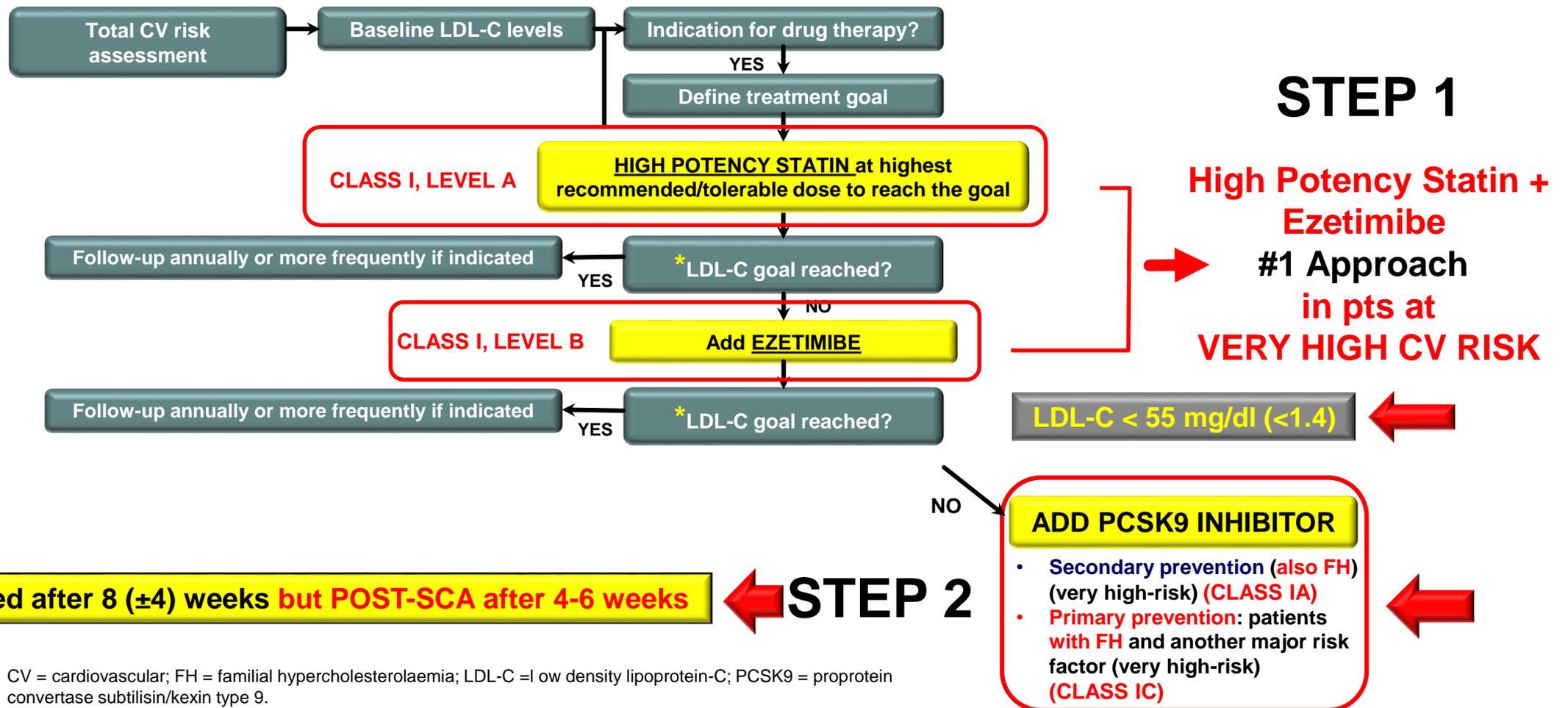
### Algorithm for managing high LDL-C levels in ASCVD patients.



\* HI statin: high-intensity statin or maximally tolerated statin therapy



## 2019 ESC/EAS GUIDELINES: TREATMENT ALGORITHM FOR PHARMACOLOGICAL LDL-C LOWERING



CV = cardiovascular; FH = familial hypercholesterolaemia; LDL-C = low density lipoprotein-C; PCSK9 = proprotein convertase subtilisin/kexin type 9.

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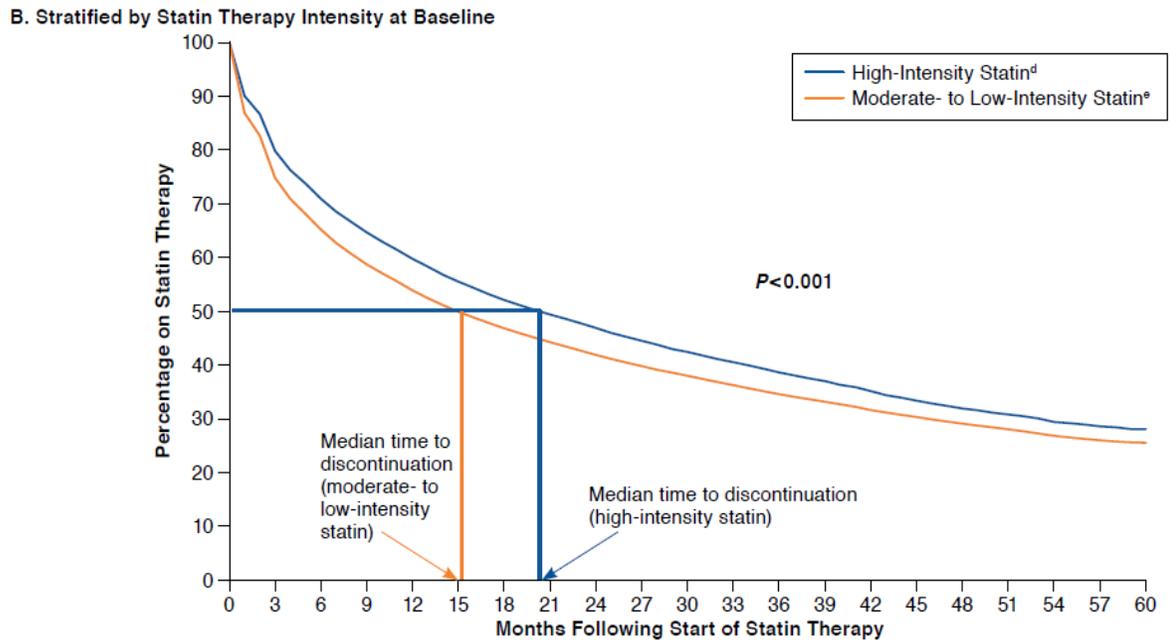
✓ **ADERENZA TERAPEUTICA**

# Patterns of Statin Use in a Real-World Population of Patients at High Cardiovascular Risk

Patterns of statin use and outcomes among 541,221 patients at **high CV risk newly initiating statin monotherapy**

Increased Risk of Stroke and Death in Patients in Non-Adherent Patients with Stable CAD

## Kaplan-Meier Analysis of Time to Statin Discontinuation



A study of 1,015 patients with **stable CAD** demonstrated that for patients who **self-reported as non-adherent**:

**↑ 4.4-fold**  
Risk of Stroke



**↑ 3.8-fold**  
Risk of CHD Death



# Better adherence to lipid-lowering treatment by a single pill than a free combination of statin and ezetimibe

F. Rea<sup>1,2</sup>, L. Savaré<sup>1,2</sup>, G. Corrao<sup>1,2</sup>, G. Mancia<sup>3</sup>

<sup>1</sup> University of Milano-Bicocca, Department of Statistics and Quantitative Methods, Milan, Italy

<sup>2</sup> National Centre for Healthcare Research and Pharmacoepidemiology, Milan, Italy

<sup>3</sup> University of Milano-Bicocca, Emeritus Professor, Milan, Italy

Healthcare Research

Lab & Pharmacoepidemiology

## AIMS

To assess adherence to lipid-lowering therapy in a large cohort of patients newly treated with statins comparing those who added ezetimibe administered separately and those who switched to the single pill combination.

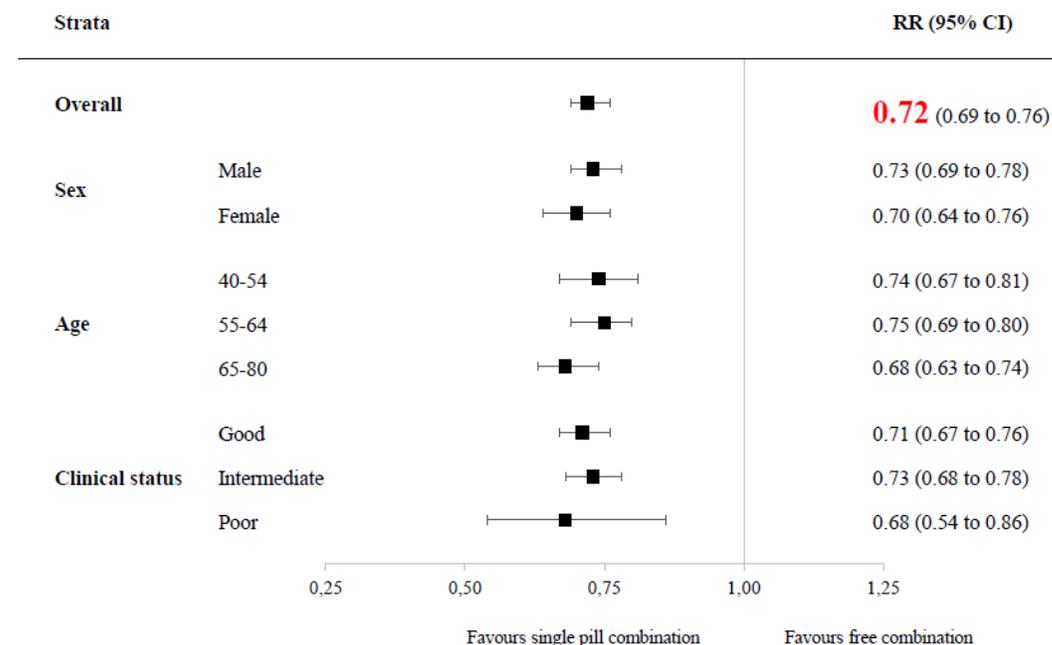
## METHODS

and, after matching, 2,238 subjects in each group were included in the study final cohort. Adherence to drug therapy was measured as the ratio between the number of days in which the drug was available and the days of follow-up (the “proportion of days covered”, PDC). PDC > 75% or < 25% were defined as high and low adherence to drug therapy, respectively. Log-binomial

**Those prescribed a SINGLE PILL COMBINATION of statin and ezetimibe, had a 85% greater odds of being adherent to treatment**

## FIGURE 1 – High adherence

**LESS PATIENTS DISCONTINUED treatment in SPC group**



Risk ratios (RR), and 95% confidence intervals (CI), estimating the association between single-pill vs free administration of a statin and ezetimibe and treatment discontinuation. 90-day period without drug considered as discontinuation

Rea, F., Savaré, L., Corrao, G. et al. Adherence to Lipid-Lowering Treatment by Single-Pill Combination of Statin and Ezetimibe. Adv Ther (2021). <https://doi.org/10.1007/s12325-021-01892-7>

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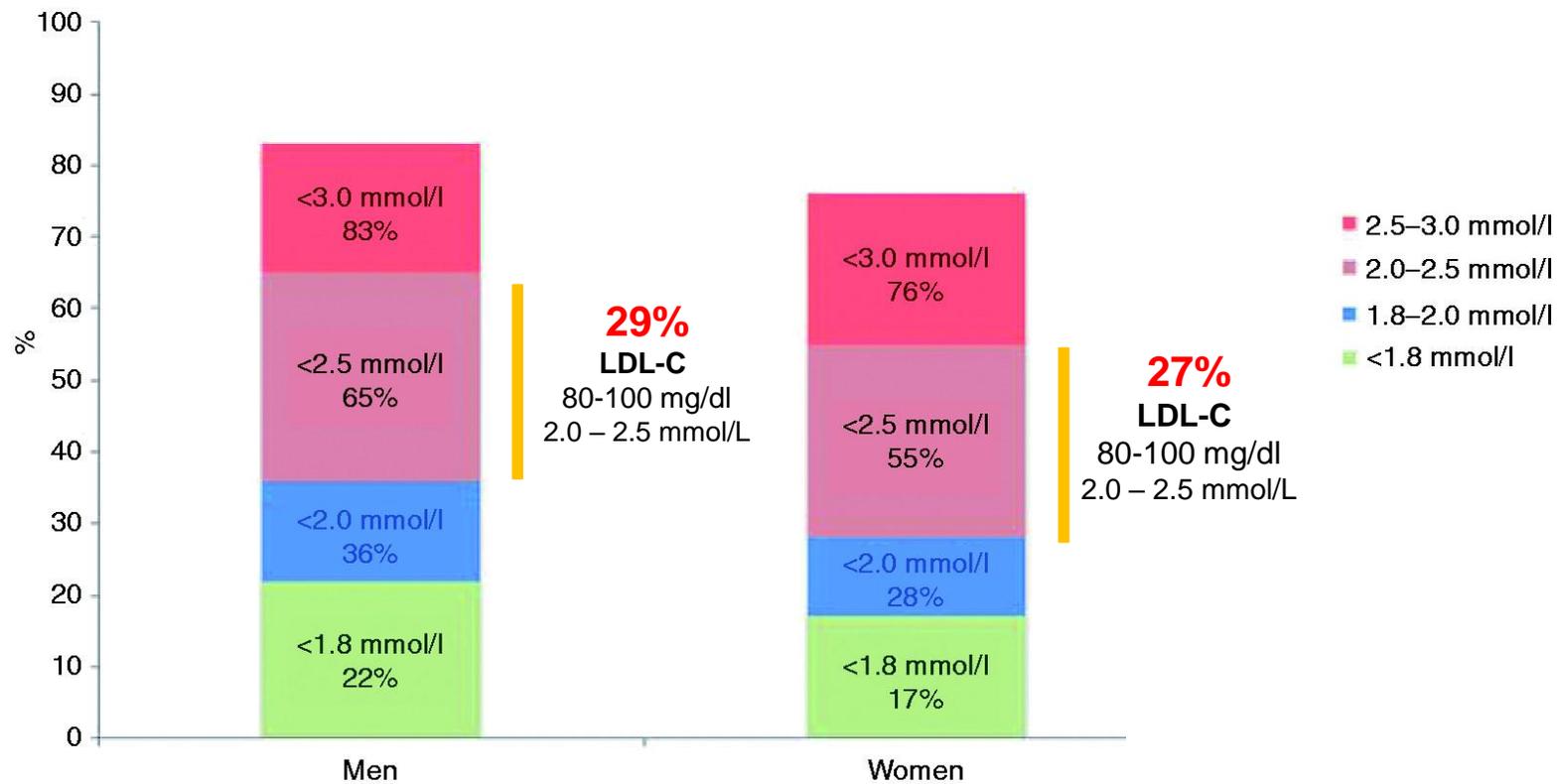
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  - ✓ ADERENZA TERAPEUTICA

## ➤ **BENEFICI:**

- ✓ RAGGIUNGIMENTO DEL GOAL TERAPEUTICO DI LDL-C ED EVENTI CV RISPARMIATI

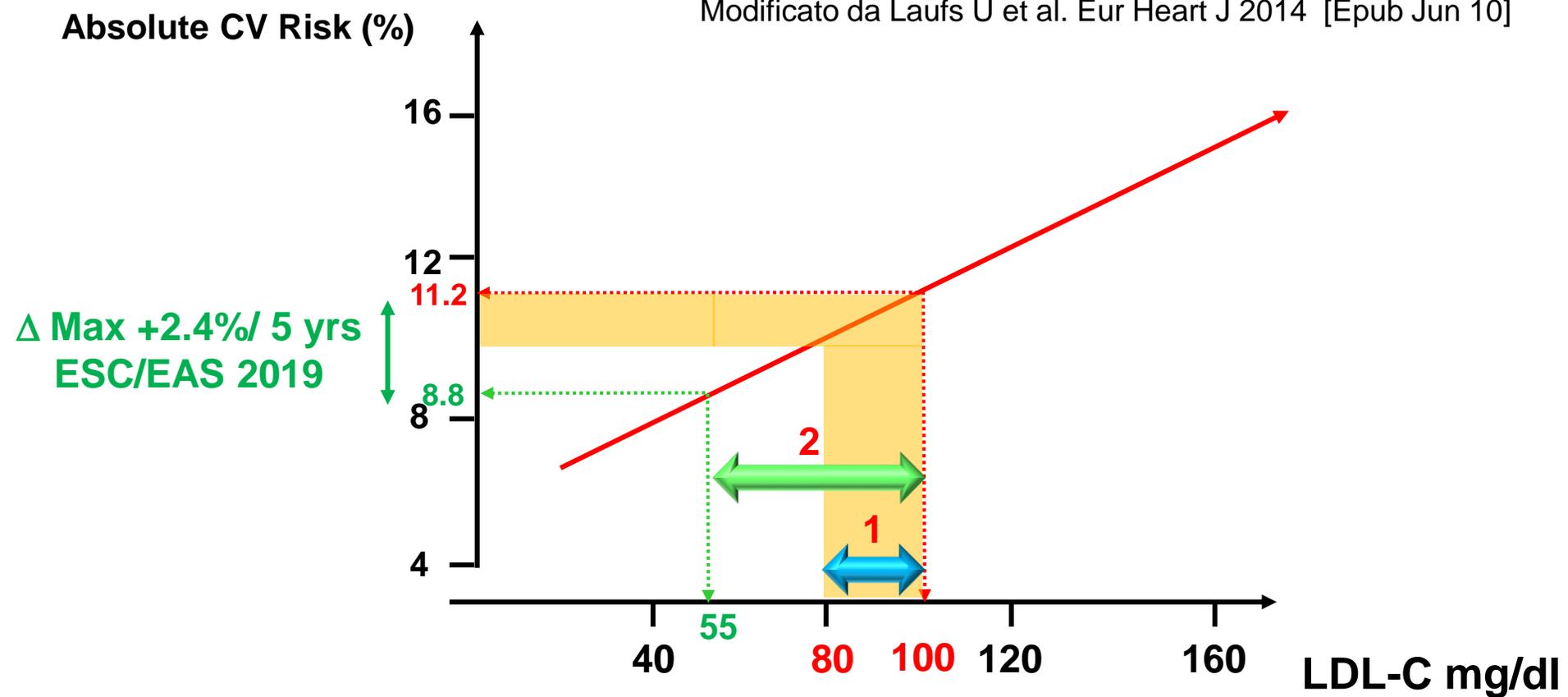
# EUROASPIRE IV



Proportions (%) at LDL-cholesterol goal in patients on lipid lowering medication by sex *at interview*.

# Expected CV absolute risk reduction *in patients at LDL-C up to 100 mg/dl if 2019 ESC/EAS goal were achieved*

Modificato da Laufs U et al. Eur Heart J 2014 [Epub Jun 10]



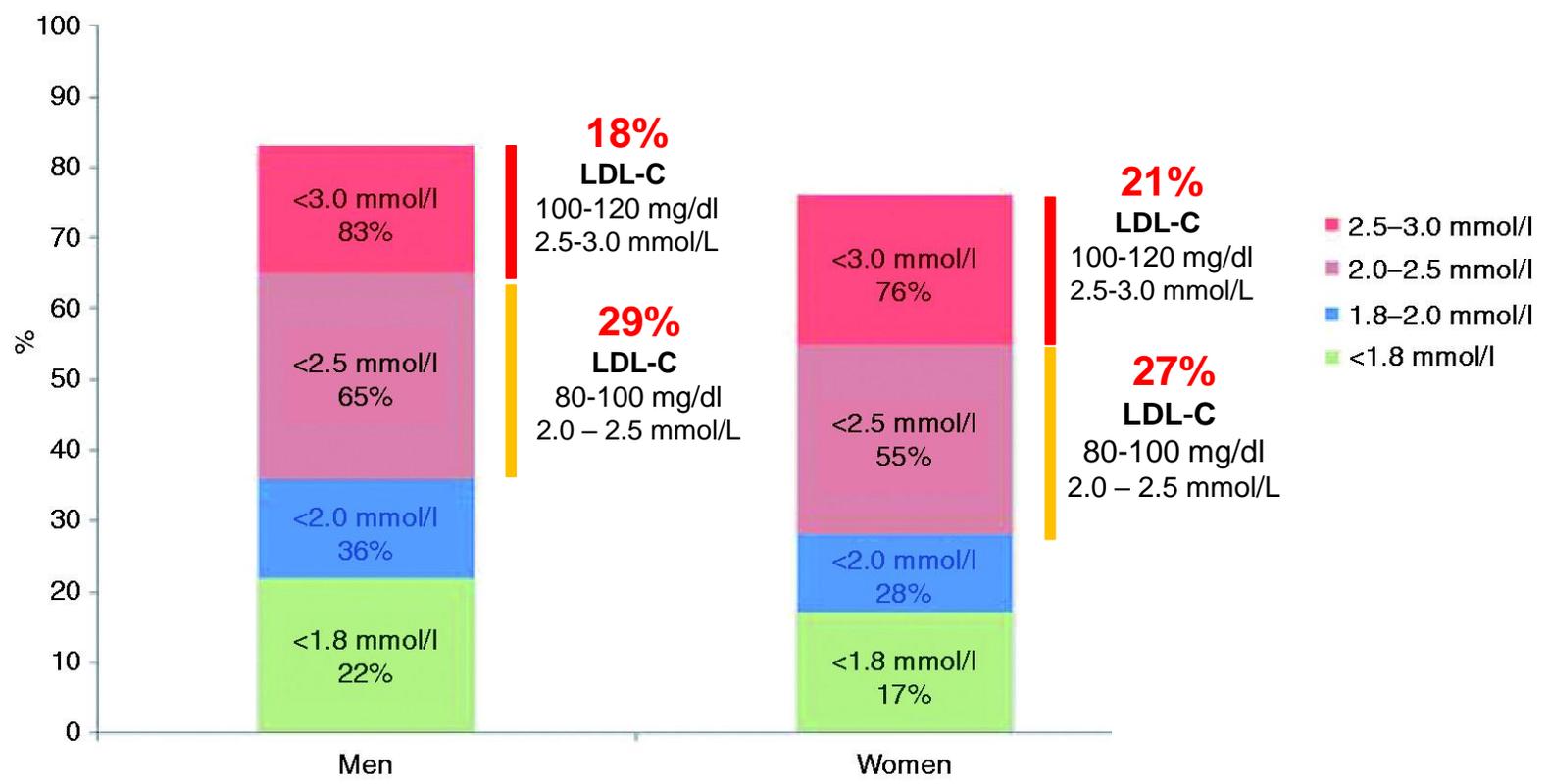
1) LDL-C= 80-100 mg/dl 2.0-2.5 mmol/L (≈30-35% of EUROASPIRE IV-V Population)

2) Achieving LDL-C goals would **SAVE up to 4.8 extra CV events/100 pts over 10 yrs (ESC/EAS 2019)**

Kotseva K et al. Eur J Prev Cardiol 2016 Apr;23(6):636-48; Kotseva et al Eur J Prev Cardiol. 2019 May;26(8):824-835; De Backer G et al Atherosclerosis. 2019 Apr 24;285:135-146.

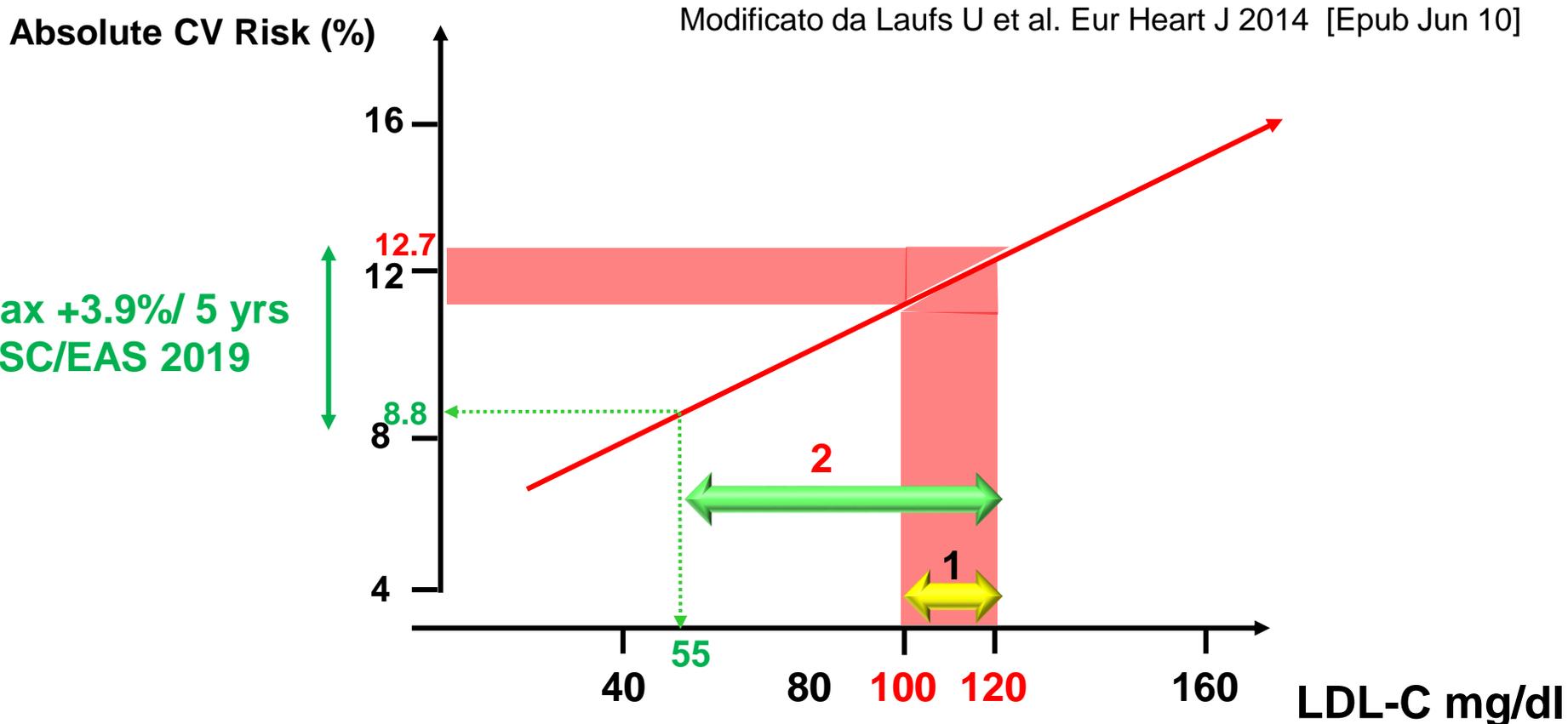
# EUROASPIRE IV

EUROSPIRE V: LDL-C >2.6 mmol/L MEN 31%, WOMEN 42



Proportions (%) at LDL-cholesterol goal in patients on lipid lowering medication by sex *at interview*.

# Expected CV absolute risk reduction *in patients at LDL-C up to 120 mg/dl* if 2019 ESC/EAS goal were achieved



1) LDL-C= 100-120 mg/dl 2.5-3.0 mmol/L (≈20% of EUROASPIRE IV Population)

2) Achieving LDL-C goals would **SAVE up to 8 extra CV events/100 pts over 10 yrs (ESC/EAS 2019)**

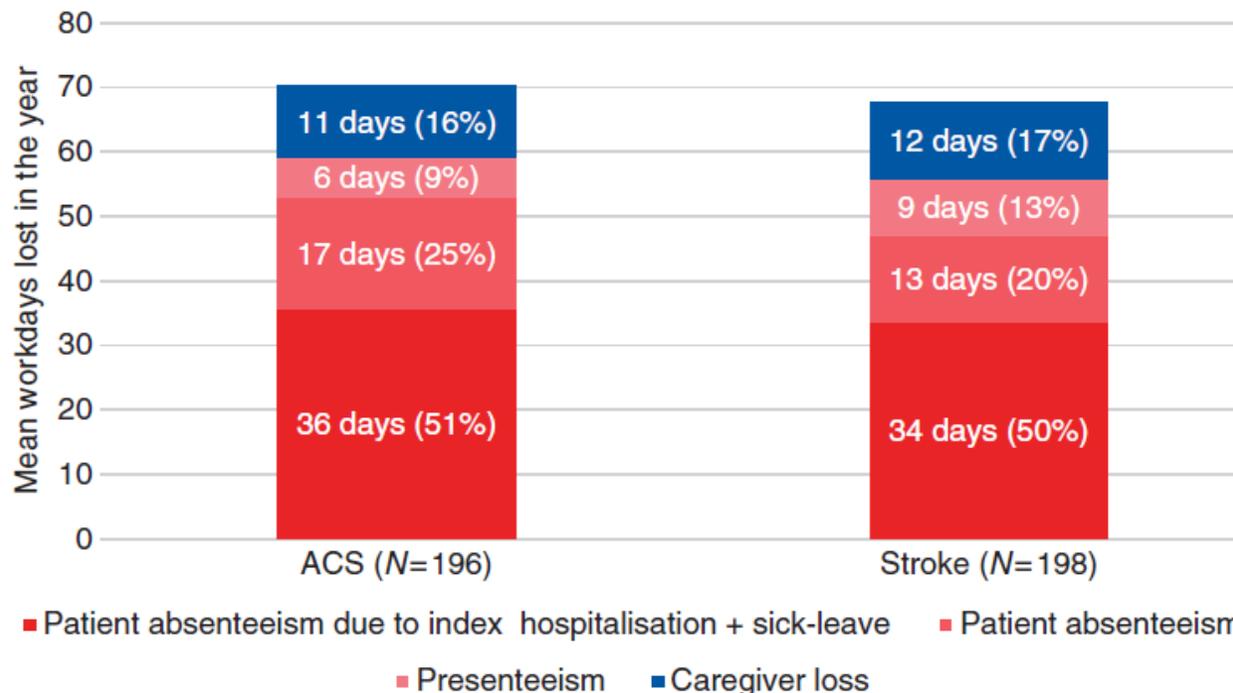
# Patient and caregiver productivity loss and indirect costs associated with cardiovascular events in Europe

Kornelia Kotseva<sup>1</sup>, Laetitia Gerlier<sup>2</sup>, Eduard Sidelnikov<sup>3</sup>, Lucie Kutikova<sup>3</sup>, Mark Lamotte<sup>2</sup>, Pierre Amarenco<sup>4</sup> and Lieven Annemans<sup>5</sup>

European Journal of Preventive Cardiology  
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## Mean patient and caregiver annual workdays lost in ACS and stroke.

Indirect cost  
**€13,953 per ACS case**



Indirect cost  
**€13,773 per stroke case**

The European Cardiovascular Disease Statistics 2018 report that indirect costs account for 47% of total cardiovascular economic burden.

# Raggiungimento dei goal terapeutici nei pazienti ipercolesterolemici: criticità e benefici

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## ➤ CRITICITA'

- NUOVI OBIETTIVI DI LDL-C: UNA SFIDA TERAPEUTICA
- STRATEGIE ATTUALI PER RAGGIUNGERE GLI OBIETTIVI DI LDL-C:
  - ✓ APPROCCIO A STEP TERAPEUTICI SEQUENZIALI
  - ✓ USO IN PRIMA BATTUTA DELLA TERAPIA DI ASSOCIAZIONE
  - ✓ ADERENZA TERAPEUTICA

## ➤ **BENEFICI:**

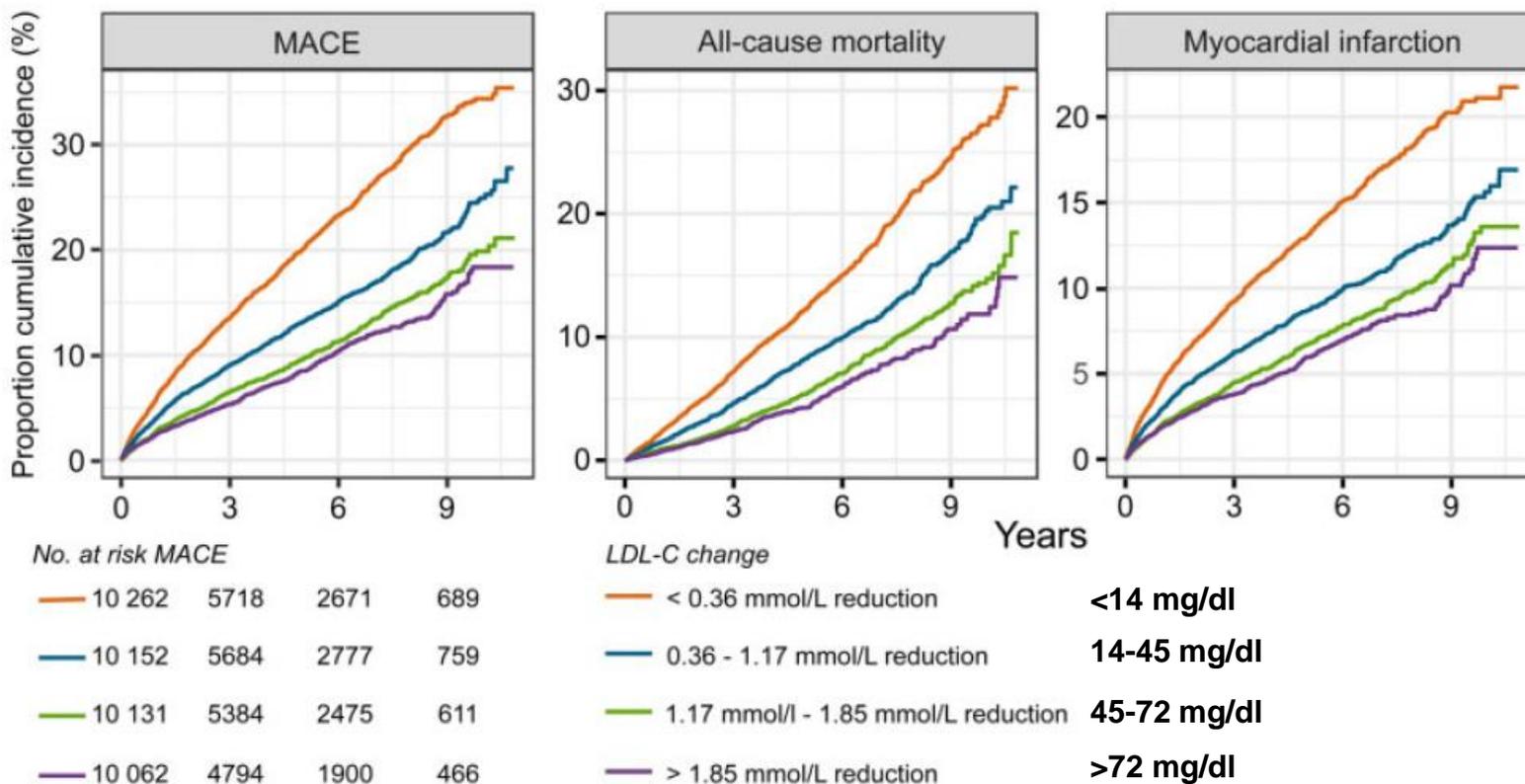
- ✓ RAGGIUNGIMENTO DEL GOAL TERAPEUTICO DI LDL-C ED EVENTI CV RISPARMIATI
- ✓ **IMPORTANZA DI RIDURRE LDL-C IN MODO EFFICACE ED IL PRIMA POSSIBILE**



# Low-density lipoprotein cholesterol reduction and statin intensity in myocardial infarction patients and major adverse outcomes: a Swedish nationwide cohort study

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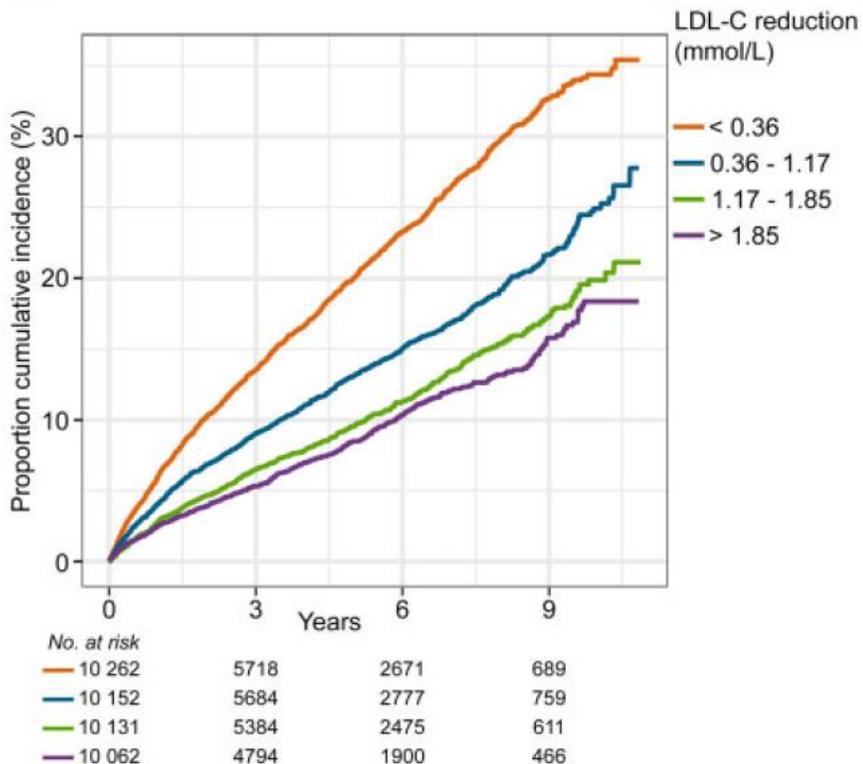
- 40 607 patients, median follow-up 3.78 years
- Admitted with MI were followed for **mortality and major CV events.**
- Changes in **LDL-C between the MI and a 6- to 10-week** follow-up visit were analysed.





# Early LDL-C Reduction in Post-MI patients

Adjusted hazard ratio and incidence rates for major adverse cardiovascular events by change in LDL-C 6-10 weeks after myocardial infarction



**6-10 weeks post-MI**

**1 mmol/L LDL-C reduction**

**25% MACE reduction**

HR for 1.85 vs 0.36 mmol/L LDL-C reduction: **0.77 (95% CI 0.70 - 0.84)**

## CONCLUSIONS:

- LARGER, EARLY LDL-C REDUCTION**, more intensive LLT after MI were associated with a **reduced hazard of all CV outcomes and all-cause mortality**.
- Earlier** lowering of LDL-C after an MI confers the **greatest** benefit.

# Raggiungimento dei goal terapeutici nei pazienti ipercolesterolemici: criticità e benefici

## ➤ CRITICITA'

- NUOVI OBIETTIVI 2019 ESC/EAS DI LDL-C RAPPRESENTANO UNA SFIDA TERAPEUTICA
- STRATEGIE ATTUALI PER RAGGIUNGERE GLI OBIETTIVI DI LDL-C:
  - ✓ APPROCCIO A STEP TERAPEUTICI SEQUENZIALI: **NON IMPLEMENTATO NEL REAL PRACTICE**, POCHI RAGGIUNGONO GLI OBIETTIVI DI LDL-C NELLA FASCIA A RISCHIO CV ALTO/MOLTO ALTO
  - ✓ **TERAPIA DI COMBINAZIONE DI PRIMA SCELTA** ASSOCIATA A >50% PAZIENTI A RISCHIO MOLTO ALTO CON LDL-C ENTRO VALORI SUGGERITI DA ESC/EAS 2019 E ADERENZA OTTIMIZZATA (ove disponibile FDC, PILLOLA UNICA)

## ➤ BENEFICI:

- ✓ RAGGIUNGIMENTO DEL GOAL TERAPEUTICO ESC/EAS 2019 DI LDL-C:
  - **RIDUZIONE** SINO A 4-8 **EVENTI** CV /100 PAZIENTI/10 ANNI (con LDL-C basale 100-120 mg/dl)
  - **RIDUZIONE DEI COSTI** SOCIO-SANITARI (risparmio di circa 14.000 Euro/evento)
- ✓ E' IMPORTANTE RIDURRE LDL-C EFFICACEMENTE E PRESTO (DOPO EVENTO CV)

# Narrowing the Gap Between Lipid Guidelines and Current Practice

**Should we encourage EARLIER AND BROADER use of COMBINATION THERAPIES in dyslipidemia ?**

**Yes,** because the **STEP BY STEP** approach:

1. Requires an optimization of LLT during FU that is not observed in real life

**Yes,** because **EARLY SYSTEMATIC COMBINATION** therapy :

1. Rapid, effective achievement of LDL-C goal in high/very high CV risk patients
2. Corresponds to a Treat to Target Strategy in line with ESC guidelines
3. Is easier to apply in practice than any algorithm
4. Associated with greater adherence with single-pill combination (SPC) *if available*

