AN EVIDENCE-BASED APPROACH TO EARLY AND AGGRESSIVE LDL REDUCTION IN POST-MI PATIENTS

BEST PRACTICES FORUM

MONDAY, MARCH 29, 2021

8:00 – 9:30 PM EST

Practical Applications and Practice Implementation Worksheet

Post-MI case presentation

1. As primary care we need to address the modifiable risk factors post MI.
2. Do not assume that patient is at target for lipids, glucose, BP, weight etc. Prove it!
3. Shared care requires good communication and follow-up.

Secondary prevention and role of cardiac rehab post-MI

1. All patients who qualify SHOULD attend cardiac rehabilitation (CR) to reduce CV mortality and hospitalizations through risk factor modification and exercise.
2. If your patient goes to a CR program that does not actively manage risk factor you are responsible to get the patient to targets as soon as possible after event. (sBP < 120, LDL < 1.8-2.0, A1c < 7%, smoking cessation) using recommended therapies (ACEi, Statin, Ezetimibe, PCSK9i, SGLT2i and GLP-RA's).
3. Identify special populations and treat them accordingly (FH – treat and cascade screen family, PAD – ASA/Riva 2.5 bid after off DAPT, atrial fib – avoid triple therapy but use DOAC/P2Y12i to reduce bleeding risk).

What are your next steps to implement this learning into your practice?

Are any patients in your practice coming to mind that you feel you need to follow up with?

Clinical/angiographic predictors of risk following MI

1. High-risk post ACS patients require intensive LDL-C reduction using high-intensity statin or maximally tolerated statin therapy.
2. The lower the LDL-C achieved, the greater the reduction in CV risk.
3. In very high-risk ASCVD, use LDL-C to 1.8 mmol/L to consider addition of non statins to statin therapy.
4. In Fourier trial, patients closer to their most recent MI, with multiple priors MIs or with multivessel disease show a greater benefit from intensive LDL reduction.

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The evidence for early and aggressive LDL lowering post-MI

1. High-intensity statin therapy (or maximally tolerated) is mandatory for all ACS patients.
2. Only 50-70% of ACS patients achieve an LDL-C <2.0 in contemporary practice. Even fewer achieve an LDL-C <1.8.
3. New CCS guidelines strongly endorse ezetimibe and/or PCSK9 inhibitors for all ACS patients with LDL > 1.8.
4. Common very-high risk features can be used to further sub-select patients best suited for PCSK9 inhibitors based on greatest absolute risk reduction.

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