



Guidance on Prescribing of Statins in Primary & Secondary Care across NW London

This document aims to provide guidance to prescribers in both primary and secondary care on the use of statins in the majority of their patients. It may not cover every condition in which it is appropriate to prescribe a statin. In certain circumstances it is accepted that patients' management may fall outside these guidelines, but it is anticipated that this should only be a relatively small number of patients compared to the overall number receiving statins. Where such variance occurs, the reason should be clearly documented and communicated between primary and secondary care as appropriate.

This document therefore aims to ensure that equitable standards of care are given to all patients across NW London and that statins are prescribed in a consistent manner across primary and secondary care. It is important to ensure that lifestyle interventions such as smoking cessation, diet modification, increasing exercise and achieving optimal weight distribution are reinforced for all patients.

Further key points to consider:

- Practitioners are currently required to meet national targets for total cholesterol as laid down within the National Service Framework for CHD and nGMSc. The recently published Joint British Societies (JBS2) guidelines, recommend more aggressive treatment targets (see pg 3). Whilst these are not currently specified as national targets, they have been endorsed by all the Royal Colleges, based on current evidence. The NW London Cardiac Network therefore recommends practitioners moving towards implementing these by identifying patients at highest risk. Further guidance will be determined locally to support the gradual phased implementation of these targets.
- NICE guidance (2006) states that 'When the decision has been made to prescribe a statin, it is recommended that therapy should usually be initiated with a drug with a low acquisition cost' There is a considerable price difference between simvastatin and atorvastatin which is likely to continue until 2011 when the patent on atorvastatin runs out
- Throughout NW London, Atorvastatin accounts for up to 49% of all statin prescribing across secondary care and up to 45% across primary care. In an average PCT with a population of 250,000, promoting and supporting a switch of appropriate patients to Simvastatin 40mg could save £500,000 per annum. Across NW London, this equates to an annual saving of approx. £3.8million within primary care alone.
- Landmark studies such as the 4S and Heart Protection Study (HPS) have used Simvastatin 40mg safely and effectively in large numbers of patients. This coupled with the considerable price difference between it and comparable doses of Atorvastatin make it the first line drug choice for the majority of patients. As such, practitioners are asked to adhere to this guidance when prescribing statins for the majority of their patients.



Guidance on Prescribing of Statins in Primary and Secondary Care across NW London

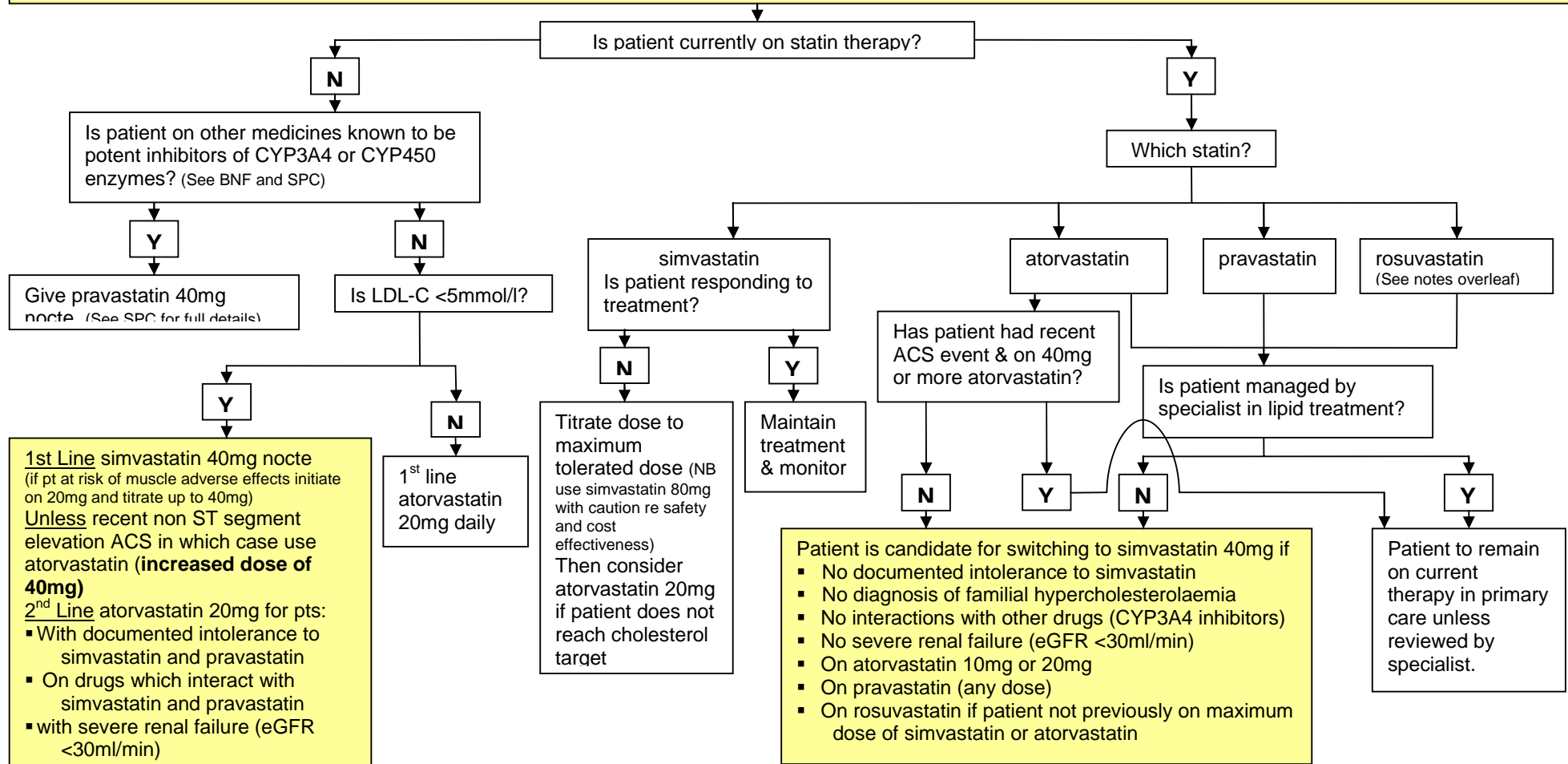


North West London Cardiac Network

Patient identified as requiring treatment with a statin

“Primary Prevention” All patients with 20% or more CVD risk over the next 10 years and all diabetic patients aged >40 years (using JBS2 calculator)

“Secondary Prevention” All patients with confirmed diagnosis of coronary heart disease or other atherosclerotic vascular disease



Produced by Frances Horne, Prescribing Adviser, on behalf of the NWLCN July 2006 Review date July 2008

If the patient does not tolerate their statin,

- change to simvastatin and add in ezetimibe or
- reduce the dose and add in ezetimibe 10mg daily
- Consider changing to pravastatin 40mg nocte
- Consider referring to lipid specialist

If the patient does not reach their cholesterol target on atorvastatin

- Trial of simvastatin 40mg and ezetimibe 10mg (first line cost effective option) before atorvastatin and ezetimibe
- Consider referring to lipid specialist

Guideline Targets

NSF National minimum targets, equivalent to the JBS audit standard
JBS Guidelines Not national targets, but aspirational targets
nGMSc This should be treated as an audit target below which to aim for all eligible diabetes, CHD and stroke patients

| Target | NSF Guidelines March 2000 | nGMSc updated for 2006-2007 | Joint British Societies Guidelines ¹ | |
|-------------------|---|---|---|----------------|
| | | | Optimal Standard | Audit Standard |
| | Primary and secondary Prevention | The practice can provide a register of all patients with diabetes, CHD and stroke | Secondary & Primary Prevention, Diabetes | |
| Total Cholesterol | <5mmol/l or reduced by 30% (whichever is greater) | 40-70% of patients on register have total cholesterol <5mmol/l | <4.0 mmol/l or 20% reduction | <5.0 mmol/l |
| LDL-C | <3mmol/l or reduced by 30% (whichever is greater) | | <2.0 mmol/l | <3.0 mmol/l |

References

¹ Joint British Societies' guidelines on prevention of cardiovascular disease in clinical practice. published December 2005 www.heartjnl.com

Risk Calculators

Cardiovascular Risk Prediction Charts are included in the back of the BNF, (does not account for ethnic or family history; ensure risk is multiplied by a factor of 1.5 for each of these)
 Online risk calculators should be available from Summer 2006 at:

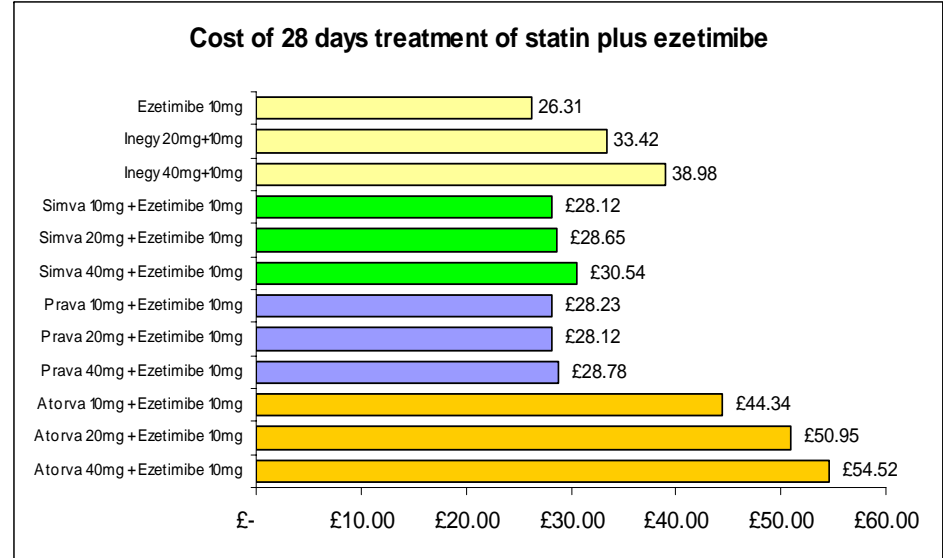
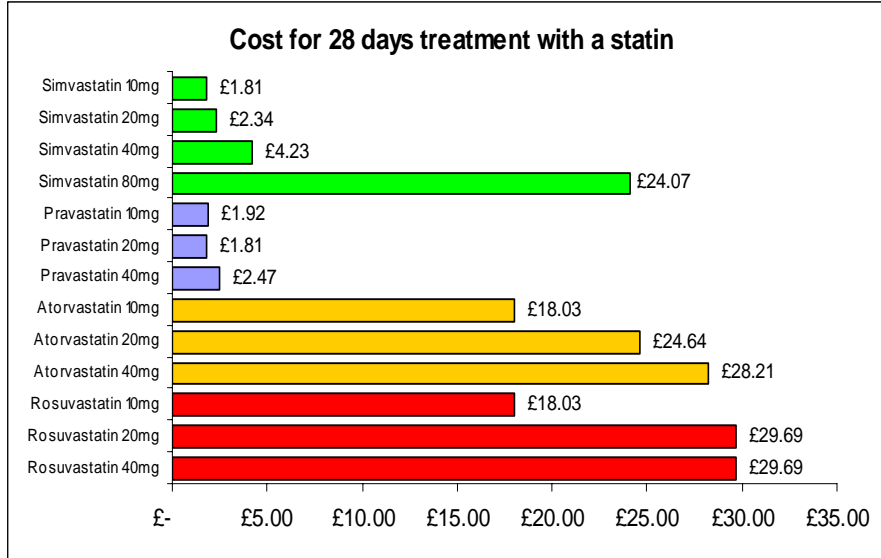
<http://www.access2information.org/health/cvra/>

High Risk Patients ¹

The following patients are likely to derive significant benefit from statin therapy

- BP>160/100 with target organ damage
- TC:HDL ratio >6
- Familial Hypercholesterolaemia
- Diabetics aged 18-39 with one or more of the following retinopathy, nephropathy, HbA1c >9%, Elevated BP requiring treatment, TC >6mmol/l, features of metabolic syndrome or FH of CVD in a first degree relative

Cost Comparative Data



Costs taken from Drug Tariff May 2006

What to consider when switching statins to ensure continued compliance and achievement of targets

- **Lifestyle Interventions**

Ensure that lifestyle interventions such as smoking cessation, diet modification and increasing exercise are reinforced

- **Use of Standard Operating Procedures**

Ensure that patient exclusions criteria are defined, patient information leaflets and blood test forms are available

- **Monitoring requirements**

Ensure LFTs are measured within 1-3 months of starting or according to local monitoring guidelines. CK for patients at risk of myopathy.

- **Dose Titration**

Ensure that dose of simvastatin is maximised before alternative treatments are initiated

Rosuvastatin

- 5mg is the recommended start dose for patients of Asian origin and those with predisposing risk factors for myopathy. The **max** recommended dose is 20mgs for those of Asian origin, those predisposed to myopathy and those receiving cocominant fibrates.
- No studies of rosuvastatin that reported clinical events as outcomes have been identified (**highlighted by NICE**)
- May not be on local formularies and therefore consultants in secondary care should not ask GPs to prescribe it.
- At this time, it is not recommended for first line use by NWLCN.