

# Pathways for optimising lipid management in secondary prevention of cardiovascular disease: purpose and development of the pathways

## Purpose of the pathways

Cardiovascular disease (CVD) is a leading cause of premature death and disability due to the consequences of stroke, myocardial infarction and heart failure. The NHS Long Term Plan outlined an ambition to support the prevention of 150,000 heart attacks, strokes and dementia cases, making CVD the largest area where lives can be saved over the next 10 years.

Lipid management in England must improve to drive better CVD outcomes – every 1 mmol/L reduction in LDL-C is tied to a 22% reduction in major vascular events after 1 year. CVD is also the largest driver of inequalities in life-expectancy in England. The excess non-covid mortality currently seen is due to cardiovascular disease.

To address the clinical priority of improved lipid management, two pathways – one for acute cardiovascular disease in secondary care and one for primary care clinicians - have been developed. These pathways meet the need to provide clear and simple guidance for clinicians on how optimal lipid management may be achieved.

- **What these pathways are:** these pathways provide an additional resource which can be used to support patient management. They have been developed to support healthcare professionals implement NICE and other relevant evidence in lipid management in secondary prevention. They should be considered alongside other relevant guidance e.g. [NICE NG 238 \(December 2023\)](#), “[Cardiovascular disease: risk assessment and reduction, including lipid modification](#)”
- **What these pathways are not:** these are not comprehensive clinical guidelines setting out all clinical scenarios, nor do they seek to set out the clinical evidence base for interventions which is covered in the relevant NICE Technology Appraisals
- These pathways define a High Intensity Statin as Atorvastatin 80 mg once daily (40 mg once daily if dose reduction considered indicated) or rosuvastatin 20 mg once daily if atorvastatin is contraindicated

## Development of the pathways

These pathways were developed in line with NICE Guidance and adapted by a Clinical Advisory Group, chaired by Professor Gary Ford (Chief Executive of Oxford AHSN and Consultant Stroke Physician) and Helen Williams, National Clinical Director of CVD Prevention, NHS England. Membership included representation from the NHS England National Clinical Directors for Stroke, Heart Disease, Diabetes & Obesity, and Primary Care, alongside primary care and secondary care clinical specialists in cardiovascular disease.

The pathways are based on the [Accelerated Access Collaborative lipid management pathway](#), as well as a primary care pathway developed by UCLPartners. The primary care pathway is supported by the broader [UCLPartners Proactive Care Frameworks](#) including comprehensive search and stratification tools and resources to support clinical care, self-management and behaviour change.

## Supporting information

- Use of these pathways, including adaptation to local need, is at the discretion of clinicians. Adoption of these pathways should follow routine local clinical governance processes
- **Lipid Optimisation Pathway following an Acute Cardiovascular Event** © Oxford Academic Health Science Network, prepared to aid clinical practice and support education activities – it can be used and reproduced for this purpose
- **Lipid Optimisation Pathway for Secondary Prevention in Primary Care** © UCLPartners 2022, developed as part of the [UCLP Proactive Care Frameworks](#) to aid clinical practice and support education activities - it can be used and reproduced for this purpose

# Lipid optimisation pathway for secondary prevention in primary care / the community<sup>1</sup>

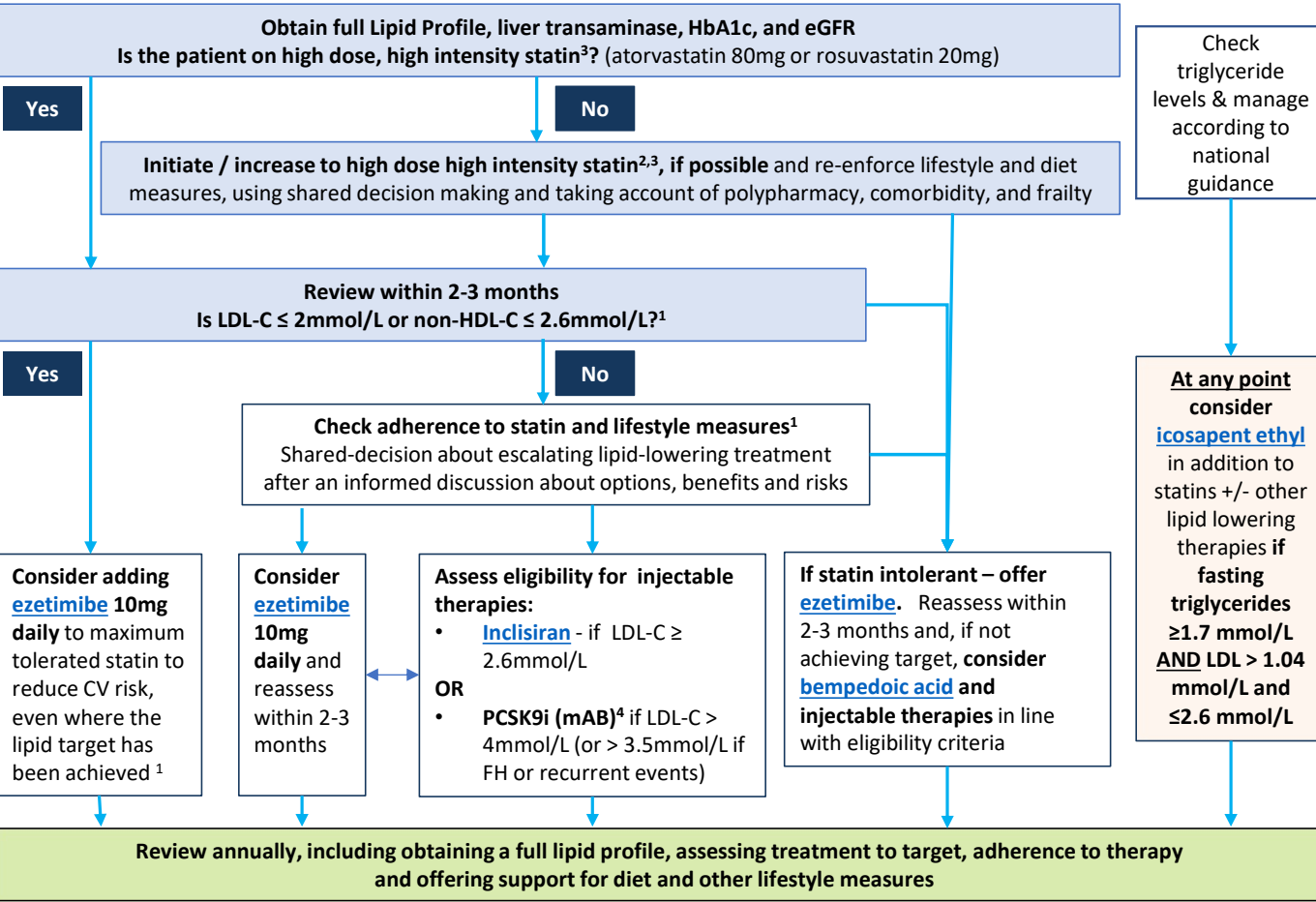
**Lipid lowering therapies should be offered to all patients with established CVD<sup>1</sup>**

- Aim to achieve LDL-C and non-HDL-C targets as a minimum, greater reductions are encouraged
- Lower targets are recommended post-acute event (please see *Lipid optimisation pathway following an acute cardiovascular or peripheral disease event*)
- Do not de-escalate therapy except where there are issues of tolerability or drug interactions
- Where an individual qualifies for injectable therapies, as per NICE technology appraisals, consider these in preference to ezetimibe to prevent lipid levels being lowered but remaining above the LDL-C target and below thresholds for initiating injectable therapies
- Consider FH if TC>7.5mmol/L or LDL-C>4.9mmol/L or non-HDL-C>5.9mmol/L with a personal or family history of confirmed CHD (<60 years) and no secondary causes
- This pathway aligns to NICE guidance NG238

1. [NICE NG238: Cardiovascular disease: risk assessment and reduction, including lipid modification](#)
2. Dose may be limited, for example if:
  - CKD: eGFR<60ml/min – recommended starting dose, atorvastatin 20mg
  - Drug interactions
  - Drug intolerance
  - Frailty
  - End of Life
3. See [statin intensity table](#). Use shared-decision making and incorporate patient preference in treatment & care decisions
4. NICE Guidance: [Evolocumab](#), [Alirocumab](#), [Inclisiran](#), [Bempedoic Acid](#), [Icosapent Ethyl](#)

Check triglyceride levels & manage according to national guidance

**At any point consider icosapent ethyl** in addition to statins +/- other lipid lowering therapies if **fasting triglycerides ≥1.7 mmol/L AND LDL > 1.04 mmol/L and ≤2.6 mmol/L**



Based on a pathway developed by  
**UCLPartners**

© UCLPartners 2022. This pathway is based upon [UCLPartners Proactive Care Frameworks](#) lipid optimisation pathway to aid clinical practice and support education activities, it can be used and reproduced for this purpose.

