

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION/SELF MANAGEMENT
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GOALS

- ✓ Decrease morbidity and mortality of atherosclerotic cardiovascular disease (ASCVD)
- ✓ Appropriately identify and treat patients at risk for ASCVD
- ✓ High-intensity statin therapy for ALL ASCVD patients

ALERTS

- Muscle pain or weakness
- No more total cholesterol or LDL treatment targets
- Minimize statin adverse effects & potential drug interactions

HYPERCHOLESTEROLEMIA DIAGNOSTIC CRITERIA/EVALUATION

For treatment of total cholesterol or LDL: Goal is no longer “treat to target” or to consider “lower is better.”¹
 Manage according to patient’s ASCVD risk.

EVALUATION:

- ✓ Assess each patient for personal ASCVD risk factors and family history ASCVD
- ✓ Obtain lipid panel (non-fasting is acceptable for screening) in:
 - males > 35 years or 20-35 years at increased risk for ASCVD
 - females > 45 years or 35-45 years at increased risk for ASCVD
- ✓ Estimate patient’s 10-year ASCVD risk group based on sex, age, race, total cholesterol, HDL, BP, history of DM, and smoking history using the newly developed Pooled Cohort Equation: <http://clinicalcalc.com/Cardiology/ASCVD/PooledCohort.aspx>

4 DEFINED STATIN BENEFIT GROUPS		
SECONDARY PREVENTION	GROUP 1	Individuals with clinical ASCVD (ACS, MI, stable angina or other arterial revascularization, stroke, TIA, or PAD of atherosclerotic origin)
PRIMARY PREVENTION	2	Individuals with LDL-C of ≥190 (age ≥ 21 years and a candidate for statin therapy)
	3	Individuals with diabetes, LDL-C of 70 to 189, age 40 to 75 years , and without clinical ASCVD (For DM patients age <40 or >75 years , or LDL-C <70 mg/dl; treatment is individualized)
	4	Non-diabetic individuals with a 10-year ASCVD risk ≥7.5%, age 40 to 75 years, with LDL of 70 to 189, and with a 10-year ASCVD risk of >7.5% (Consider treatment for primary prevention in individuals with a 10-year ASCVD risk of 5 to 7.5%)

TREATMENT

- Healthy lifestyle changes: a 3 month trial of lifestyle changes such as diet, exercise, weight loss, smoking cessation, and control of HTN and/or DM may be appropriate in groups 2, 3, 4.
- Prior to statin initiation: TSH, ALT, CK, A1C if diabetic status is unknown.
- Statin therapy: Strongly recommended as first line therapy for all dyslipidemias when medication is indicated.
- Non-statin therapies: (e.g., ezetimibe, fibrates, fish oil, niacin) alone or in combination with statins DO NOT provide acceptable risk reduction benefits compared to adverse effects. With a few exceptions, these agents should be avoided.
- Statin intensity: Initiate or continue the appropriate intensity of statin therapy for all four of the defined statin benefit groups (see algorithm page 2).
- Statin intolerance: If patient cannot tolerate statin due to muscle weakness, muscle pain, or tenderness: re-address lifestyle issues, decrease statin dose, try another statin, check vitamin D levels and replace (low levels associated with statin myopathy), if low evaluate for other conditions that may cause muscle weakness.
- There are limited recommendations for treatment of individuals who are not in the 4 statin benefit treatment groups described above. In these individuals whose 10-year risk is < 7.5%, or when the decision is unclear, other factors (family history of premature CAD, LDL > 160 mg/dl, increased C-reactive protein [CRP] greater than 2.0, coronary calcium greater than 300, ABI < 0.9) should be considered.
- There is insufficient data to make specific recommendations regarding statin therapy in the following groups: NYHA class 2-4 CHF, dialysis, HIV patients, and solid organ transplant patients.

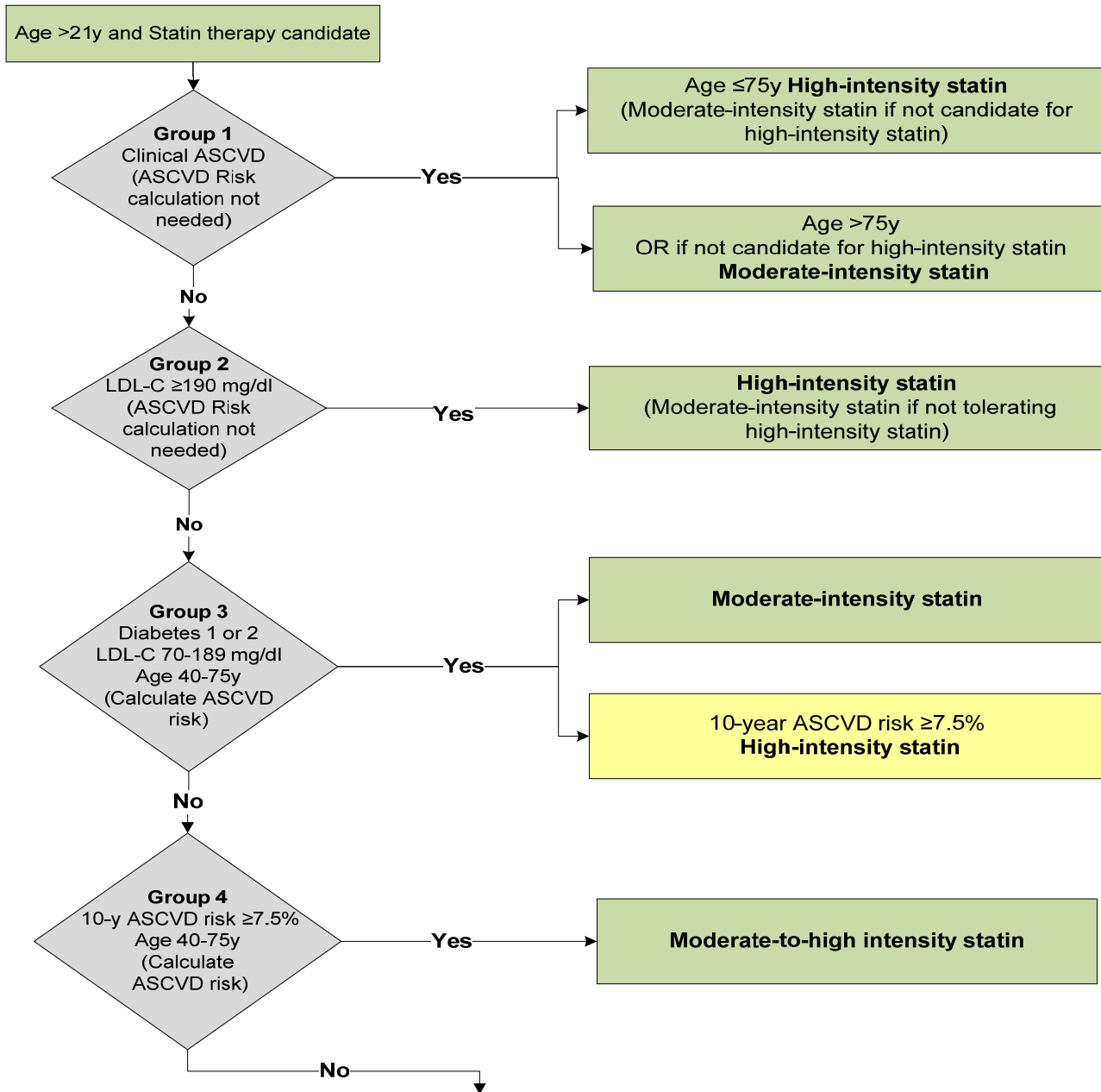
MONITORING

- Prior to statin therapy: assess response to trial of lifestyle changes
- During statin therapy:
 - ⇒ If symptomatic in the first 3 months of rx:
 - ◆ check ALT, CK
 - ◆ search for drug-drug interactions
 - ◆ decrease statin dose, try another statin
 - ◆ check vitamin D levels and replace if low
 - ◆ check TSH
 - ⇒ If asymptomatic: follow up in 6-12 months as appropriate
 - ⇒ Routine CK /ALT testing not indicated
 - ⇒ Annual: lipid panel for stable long term statin therapy patients (more frequent if indicated to monitor patient adherence).

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FOUR STATIN THERAPY BENEFIT GROUPS ALGORITHM



Reassessment:

- In individuals aged 40-75 y without clinical ASCVD or diabetes and with LDL-C 70-189 mg/dl not receiving cholesterol-lowering drug therapy, calculate 10-year ASCVD risk every 4-6 years.
- Consider treatment for those with ASCVD risk factor 5-7.5%.
- **Statin benefits less clear in other groups:**
In selected individuals, consider additional factors influencing ASCVD risk and potential ASCVD risk benefits and adverse effects, drug-drug interactions, and patient preferences for statin treatment.

*ASCVD risks include nonfatal MI, CHD death, nonfatal and fatal stroke

**<http://clinical.com/Cardiology/ASCVD/PooledCohort.aspx>

Source: Adapted from 2013 ACC/AHA Blood Cholesterol Guidelines pg S9; downloaded from <http://circ.ahajournals.org> by guest on July 9, 2015

High-intensity statin	Moderate-intensity statin	Low-intensity statin
Lowers LDL-C ≥50%	Lowers LDL-C 30-50%	Lowers LDL-C <30% <i>Use with high or moderate-intensity statin intolerance</i>
Atorvastatin 40-80 mg daily	Atorvastatin 10 –20 mg/d Simvastatin 20- 40 mg/d	Simvastatin 10 mg/d

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HYPERTRIGLYCERIDEMIA DIAGNOSTIC CRITERIA/EVALUATION

<p>DIAGNOSIS:</p> <ul style="list-style-type: none"> • Confirm diagnosis based on fasting triglyceride level >150 mg/dl^{1,3} • Mild-moderate hypertriglyceridemia diagnosis aids in evaluation of cardiovascular risk¹ • Severe or very severe hypertriglyceridemia should be considered a risk for pancreatitis³ • Patients with triglycerides >500 mg/dl should be evaluated for a genetic disorder of lipid metabolism (primary dyslipidemia)
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TRIGLYCERIDE LEVEL		GOAL	INTERVENTION
Mild Hypertriglyceridemia	150-199 mg/dl	Reduce ASCVD risk	<ul style="list-style-type: none"> • Lifestyle changes: especially appropriate diet composition, physical activity, weight reduction in overweight and obese • Evaluate all patients with hypertriglyceridemia for secondary causes¹ • Statin indicated for mild to moderate triglyceride elevation (proven to be of most benefit to reduce CV risk) • Avoid fibrates in mild-moderate hypertriglyceridemia (increased risk of pancreatitis)
Moderate Hypertriglyceridemia	200-999 mg/dl		
Severe Hypertriglyceridemia	1000-1999 mg/dl	Reduce pancreatitis risk Reduce ASCVD risk	<ul style="list-style-type: none"> • Avoid alcohol abuse • Reduce dietary fat and simple carbohydrate intake • Fibrate indicated first line therapy for severe to very severe hypertriglyceridemia, AVOID gemfibrozil with statin • Fenofibrate may be considered concomitantly with a low or moderate-intensity statin only if the benefits from ASCVD risk reduction or triglyceride lowering when triglycerides are >500 mg/dl are judged to outweigh the potential risk for adverse effects (Renal status should be evaluated before fenofibrate initiation (see page 6) • Nicotinic acid: doses of 1500-2000 mg/day are required to reduce triglycerides. Flushing is a very significant adverse effect (occurs in 92% of patients). Reduce incidence by starting at low dose and increasing slowly. Premedication 30 minutes prior to niacin dose with 325mg aspirin or 200 mg ibuprofen can alleviate flushing. Patient adherence with niacin over time is poor, 52% remain on therapy at 1 year, 29% at 4 years
Very Severe Hypertriglyceridemia	≥ 2000 mg/dl		

SECONDARY CAUSES OF DYSLIPIDEMIA

CONDITIONS	DRUGS (direct or by causing weight gain)
<ul style="list-style-type: none"> • Alcohol, excessive intake • Diabetes mellitus, uncontrolled • Cholestatic liver disease • Nephrotic syndrome • Chronic renal failure • Hypothyroidism • Smoking • Obesity • Very low fat diet • High intake refined carbohydrates • Pregnancy (cholesterol/triglycerides increase throughout pregnancy- medications contraindicated during pregnancy and lactation) 	<ul style="list-style-type: none"> • Thiazide diuretics • Beta blockers • Oral estrogens • Atypical antipsychotics (metabolic syndrome) • Tamoxifen • Glucocorticoids • Antiretroviral medications (esp. protease inhibitors) • Retinoids • Cyclosporine

1. Berglund, L, Brunzell, JD, Goldberg, AC, Sacks, F, Murad, MH, Stalenhoef, AFH. Evaluation and Treatment of Hypertriglyceridemia: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab.* 2012 Sep;97(9): 2969-2989.
 2. *UpToDate*: An Approach to the patient with hypertiglyceridemia. Rosenson, RS, Dec 9, 2014.
 3. *UpToDate*: Hypertriglyceridemia-induced acute pancreatitis. Gelrud, A, Whitcomb, DC. Apr 23, 2013.
 4. Stone NJ, Robinson J, Lichtenstein AH, Bairey Merz CN, Lloyd-Jones DM, Blum CB, McBride P, Eckel RH, Schwartz JS, Goldberg AC, Shero ST, Gordon D, Smith Jr SC, Levy D, Watson K, Wilson PWF, 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, *Journal of the American College of Cardiology* (2013), doi: 10.1016/j.jacc.2013.11.002.

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION/SELF MANAGEMENT
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MEDICATIONS

MEDICATION	DOSING	ADVERSE EFFECTS/ INTERACTIONS*	COMMENTS
HMG CoA REDUCTASE INHIBITORS (STATINS) - Risk of skeletal muscle effects (e.g., myopathy, rhabdomyolysis) increase with higher doses and concomitant use of certain drugs. Predisposing factors include: age >65, female gender, uncontrolled hypothyroidism, and renal impairment			
Simvastatin ZOCOR® Tablet: 5 mg, 10 mg, 20 mg, 40 mg 80 mg tabs unavailable within CCHCS - use 40 mg x 2 tabs \$	Usual dose: 10-40 mg once daily in evening <u>MODERATE-INTENSITY</u> 30% to <50% reduction in LDL: 20-40 mg once daily in evening Dose adjustments: Concomitant verapamil, diltiazem, or dronedarone: max 10 mg/day; Concomitant amiodarone, amlodipine, ranolazine, lomitapide: max 20 mg/day Renal dosing: CrCl >20 ml/min: No adjustment CrCl ≤20 ml/min: 5 mg/day, initially	Adverse effects <ul style="list-style-type: none"> • Myopathy, rhabdomyolysis • Increased liver enzymes Drug interactions: <ul style="list-style-type: none"> • Contraindicated with strong CYP3A4 inhibitors (e.g., erythromycin, clarithromycin, itraconazole, ketoconazole, posaconazole, voriconazole, HIV protease inhibitors, nefazodone, cobicistat), cyclosporine, danazol, gemfibrozil • Use caution with warfarin, niacin, fibrates, digoxin, colchicine 	CCHCS PREFERRED AGENT Note: 80 mg dose is associated with elevated risk of muscle injury. FDA recommends 80 mg dose only for patients who have been taking this dose for at least 12 months Contraindications <ul style="list-style-type: none"> • Active liver disease or unexplained, persistent elevations of serum transaminases • Pregnancy
Atorvastatin LIPITOR® Tablet: 10 mg, 20 mg, 40 mg, 80 mg \$	Usual dose: 10-80 mg once daily <u>MODERATE-INTENSITY</u> 30% to <50% reduction in LDL: 10-20 mg once daily <u>HIGH-INTENSITY</u> ≥ 50% reduction in LDL: 80 mg once daily, 40 mg once daily if 80 mg not tolerated Dose adjustments: Concomitant clarithromycin, itraconazole, saquinavir plus ritonavir, darunavir plus ritonavir, fosamprenavir, fosamprenavir plus ritonavir: max 20 mg/day Concomitant nelfinavir: max 40 mg/day Renal dosing: No adjustment needed	Adverse effects <ul style="list-style-type: none"> • Myopathy, rhabdomyolysis • Increased liver enzymes Drug interactions <ul style="list-style-type: none"> • Contraindicated with gemfibrozil, cyclosporine, posaconazole, certain HIV protease inhibitors (tipranavir plus ritonavir) • Use caution and lowest necessary dose with HIV protease inhibitor (lopinavir plus ritonavir) • Consider cautious dosing with niacin or fibrates (avoid gemfibrozil) • Use caution with digoxin, warfarin, colchicine, oral contraceptives 	Contraindications <ul style="list-style-type: none"> • Active liver disease or unexplained, persistent elevations of serum transaminases • Pregnancy
Pravastatin PRAVACHOL® Tablet: 10 mg, 20 mg, 40 mg \$\$	Usual dose: 20-80 mg once daily <u>MODERATE-INTENSITY</u> 30% to <50% reduction in LDL: 40-80 mg once daily Dose adjustments Concomitant cyclosporine: max 20 mg/d Concomitant clarithromycin: max 40 mg/day Renal Dosing: CrCl <30 ml/min: initial dose: 10 mg/day	Adverse effects <ul style="list-style-type: none"> • Myopathy, rhabdomyolysis • Increased liver enzymes Drug interactions <ul style="list-style-type: none"> • Pravastatin may be less likely to interact with other drugs • Use caution with niacin or fibrates (avoid gemfibrozil) • Consider dose reduction with niacin dose ≥ 1000 mg/day 	CCHCS RESTRICTION Use restricted to patients on Coumadin®, HIV protease inhibitors, cyclosporine, or other medications impacted by the cytochrome P450 enzyme system Contraindications <ul style="list-style-type: none"> • Active liver disease or unexplained, persistent elevation serum transaminases • Pregnancy
Rosuvastatin CRESTOR® Tablet: 5 mg, 10 mg, 20 mg, 40 mg \$\$\$\$	Usual dose: 5-40 mg once daily <u>MODERATE-INTENSITY</u> 30% to <50% LDL reduction: 5-10 mg once/day <u>HIGH-INTENSITY</u> ≥50% LDL reduction: 20-40 mg once daily Dose adjustments: Concomitant cyclosporine: max 5 mg/d Concomitant lopinavir/ritonavir or atazanavir/ritonavir: max 10 mg/day Renal Dosing: CrCl <30 ml/min: initially 5 mg/day; max 10 mg/day	Adverse effects <ul style="list-style-type: none"> • Myopathy, rhabdomyolysis • Increased liver enzymes Drug interactions <ul style="list-style-type: none"> • Rosuvastatin may be less likely to interact with other drugs • Use caution with niacin or fibrates (avoid gemfibrozil) • Use caution with protease inhibitors/ritonavir combinations, warfarin, colchicine 	Contraindications <ul style="list-style-type: none"> • Active liver disease or unexplained, persistent elevations of serum transaminases • Pregnancy For Asian patients, consider 5 mg/day starting dose

Bold = Formulary

*See prescribing information for complete description of adverse effects and drug interactions.

SUMMARY

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PATIENT EDUCATION/SELF MANAGEMENT

MEDICATIONS CONTINUED

MEDICATION	DOSING	ADVERSE EFFECTS/ INTERACTIONS*	COMMENTS
HMG CoA REDUCTASE INHIBITORS (STATINS) - Risk of skeletal muscle effects (e.g., myopathy, rhabdomyolysis) increase with higher doses and concomitant use of certain drugs. Predisposing factors include: age >65, female gender, uncontrolled hypothyroidism, and renal impairment			
Fluvastatin Lescol [®] , Lescol [®] XL Capsule, immediate-release: 20 mg, 40 mg Tablet, extended-release: 80 mg \$\$-\$\$\$\$	Usual dose: 20-40 mg once daily at bedtime or twice daily <u>MODERATE-INTENSITY</u> 30% to <50% reduction in LDL: 40 mg (IR) twice daily or 80 mg (XL) once daily Dose adjustments: Concomitant cyclosporine or Fluconazole, max 20 mg twice daily Renal dosing: Mild-moderate impairment: no adjustment; Severe impairment/HD/PD: not defined	Adverse effects <ul style="list-style-type: none"> • Headache • Nausea • Dyspepsia • Myopathy, rhabdomyolysis • Increased liver enzymes Drug interactions <ul style="list-style-type: none"> • Fluvastatin may be less likely to interact with other drugs • Contraindicated with gemfibrozil • Use caution with niacin, fibrates, glyburide, phenytoin, warfarin, colchicine 	Contraindications <ul style="list-style-type: none"> • Pregnancy • Active liver disease or persistent elevation of LFT's
Pitavastatin Livalo [®] Tablet: 1 mg, 2 mg, 4 mg \$\$\$\$	Usual dose: 1-4 mg once daily <u>MODERATE-INTENSITY</u> 30% to <50% reduction in LDL: 2-4 mg once daily in the evening Dose adjustments: Max 1 mg/day: Concomitant erythromycin Max 2 mg/day: Concomitant rifampin Renal dosing: CrCl <60 ml/min or HD: start 1 mg daily, max 2 mg/day	Adverse effects <ul style="list-style-type: none"> • Myopathy, rhabdomyolysis • Increased liver enzymes Drug interactions <ul style="list-style-type: none"> • Pitavastatin may be less likely to interact with other drugs • Contraindicated with cyclosporine and gemfibrozil • Use caution with fibrates, niacin, colchicine • Consider dosage reduction with niacin 	Contraindications <ul style="list-style-type: none"> • Pregnancy • Active liver disease or persistent elevation of LFT's

*See prescribing information for complete description of adverse effects and drug interactions.

FACTORS TO CONSIDER IN STATIN SELECTION					
	Most reduction in LDL	Preferred with renal impairment	Preferred with significant liver disease	Fewer drug interactions	Possibly less myopathy
Simvastatin	Yes				
Atorvastatin	Yes	Yes			
Pravastatin			Yes	Yes	Yes
Rosuvastatin*	Yes			Yes	
Fluvastatin*		Yes		Yes	Yes
Pitavastatin*				Yes	

Bold = Formulary

*Nonformulary

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MEDICATIONS CONTINUED

MEDICATION	DOSING	ADVERSE EFFECTS/ INTERACTIONS*	COMMENTS
AGENTS LISTED BELOW ARE NOT GENERALLY RECOMMENDED FOR USE IN MANAGEMENT OF DYSLIPIDEMIA			
FIBRIC ACID DERIVATIVES			
Note: Increases in creatine kinase (CK), increased risk of rhabdomyolysis, and myoglobinuria leading to acute renal failure are associated with concurrent use of fibrates and statins (significantly higher rate observed with gemfibrozil), particularly in the elderly, patients with diabetes, renal failure, or hypothyroidism			
Fenofibrate TRICOR® Tablet: 48 mg, 145 mg \$\$	Primary hypercholesterolemia or mixed dyslipidemia: 145 mg orally once daily Severe hypertriglyceridemia: 48-145 mg orally once daily Max dose: 145 mg/day Renal dosing: CrCl 30-80 ml/min: 48 mg, initially CrCl <30 ml/min: Contraindicated	Adverse effects <ul style="list-style-type: none"> Dyspepsia Gallstones Myopathy Drug interactions <ul style="list-style-type: none"> Use caution with warfarin, bile acid sequestrants, colchicine immunosuppressants (e.g., cyclosporine, tacrolimus) 	FENOFIBRATE AND KIDNEYS <ul style="list-style-type: none"> Renal status should be evaluated before fenofibrate initiation, within 3 months after initiation, and every 6 months thereafter Assess renal safety with both serum creatinine level and estimated GFR based on creatinine Contraindications <ul style="list-style-type: none"> Severe renal dysfunction (CrCl <30 ml/min) Active liver disease Gallbladder disease
Gemfibrozil LOPID® Tablet: 600 mg \$	Initial and maintenance dose: 600 mg orally twice daily, 30 minutes before morning and evening meals Renal dosing: CrCl 10-50 ml/min: Consider alternative therapy CrCl <10 ml/min: Contraindicated	Adverse effects <ul style="list-style-type: none"> Dyspepsia Gallstones Myopathy Drug interactions <ul style="list-style-type: none"> Avoid concomitant use with statins Use caution with warfarin, bile acid sequestrants, colchicine, cyclosporine Contraindicated with dasabuvir, repaglinide 	Contraindications <ul style="list-style-type: none"> Severe renal dysfunction Severe hepatic dysfunction, including biliary cirrhosis Gallbladder disease
NICOTINIC ACID			
Niacin Immediate release tablets: 250 mg, 500 mg \$	Initial: 250 mg orally once daily; titrate every 4-7 days to 1.5-2 g in divided doses; after 2 months at this dose if hyperlipidemia is not adequately controlled, increase at 2-4 week intervals to 3 g/d in divided doses. (See comments on nicotinic acid page 3) Maintenance: 1-2 g orally 2-3 times daily Max dose: 6 g/d Take with food Renal dosing: Use caution in renal impairment, dosing not available	Adverse effects <ul style="list-style-type: none"> Flushing Hyperglycemia Hyperuricemia (or gout) Upper GI distress Hepatotoxicity Pruritus Drug interactions: <ul style="list-style-type: none"> Use caution with statins Bile acid sequestrants may decrease absorption Ethanol may increase side effects of flushing and pruritus 	Contraindications <ul style="list-style-type: none"> Active liver disease Active peptic ulcer Arterial bleeding Severe gout Caution in patients with diabetes, renal disease, unstable angina Avoid hot drinks or food around time of niacin administration Pretreat with aspirin or ibuprofen 30 minutes before each dose to reduce severity and frequency of flushing, pruritus, and GI distress
BILE ACID SEQUESTRANTS			
Cholestyramine QUESTRAN® Powder: 4 g \$\$\$	Initial dose: 4 g orally 1-2 times daily before meals (mixed in 60-180 ml of noncarbonated beverage) Maintenance dose: 8-16 g/day in 2 divided doses before meals Max dose: 24 g/day Renal dosing: No adjustment needed	Adverse effects <ul style="list-style-type: none"> Constipation Gastrointestinal distress Drug interactions <ul style="list-style-type: none"> Decreases absorption of other drugs Administer other drugs at least 1 hour before or at least 4-6 hours after each dose 	NONFORMULARY AND NOT RECOMMENDED IN CCHCS Contraindications <ul style="list-style-type: none"> Complete biliary obstruction (bile is not secreted into the intestine) Patients with TG > 400 mg/dl GI obstruction

PATIENT EDUCATION/SELF MANAGEMENT

Dyslipidemia (High Cholesterol)

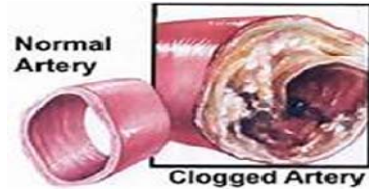
What You Should Know

What is dyslipidemia or high cholesterol?

- Abnormalities in cholesterol and other lipids (fats) in your blood which may cause clogging of arteries in your heart or other parts of your body.

Why is dyslipidemia important?

- Dyslipidemia is a risk factor for heart attacks and strokes.
- Treating dyslipidemia will help you avoid a heart attack or stroke.



How can I tell if I have dyslipidemia?

- When you have dyslipidemia, you do not have symptoms.
- Your health care provider will order a test that measures the amount of lipids in your blood.

How do I know if I need the test?

- Your health care provider will check your lipids/cholesterol if :

You have a history of:

- Previous heart attack
- Diabetes mellitus
- High blood pressure
- Cigarette smoking

You are:

- Overweight or obese
- Physically Inactive
- A man more than 44 years old
- A woman more than 54 years old

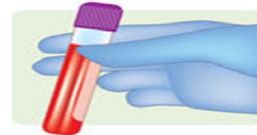
You have:

- Family history of early heart disease

How is dyslipidemia or “high cholesterol” treated?

Treatment depends on:

- your lipids levels
- your risk of heart attack
- your general health



Your primary care provider may give you a lipid-lowering medication to lower your cholesterol.

What You Should Do

Modify your daily routine and activities to lower your cholesterol:

- Lose weight
- Exercise
- Stop smoking
- Eat more fruits and vegetables
- Reduce fat in your diet (meat, milk, eggs, butter, cheese, packaged foods and snack items like cookies, crackers and chips)
- Take your medications as directed
- Report medication side effects
 - ⇒ Muscle aches are commonly reported and may or may not be due to your medicine
- Get blood tests as recommended by your health care team



EDUCACIÓN AL PACIENTE/AUTOUIDADOS

Dislipidemia (Colesterol alto)

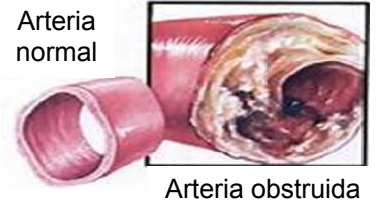
LO QUE USTED DEBE SABER

¿Qué es la dislipidemia o colesterol alto?

- Es la alteración en los niveles de colesterol y otros lípidos (grasas) en su sangre que puede causar obstrucciones en las arterias de su corazón y otras partes de su organismo.

¿Por qué es importante la dislipidemia?

- La dislipidemia es un factor de riesgo de ataques cardíacos y derramos cerebrales.
- Tratar la dislipidemia le ayudará a evitar un ataque cardíaco o un derrame cerebral.



¿Cómo puedo saber si sufro de dislipidemia?

- La dislipidemia no presenta síntomas.
- Su médico de cabecera le dará una orden para una prueba que mide la cantidad de lípidos en su sangre.

¿Cómo saber si necesito la prueba?

- Su médico de cabecera le hará la prueba de lípidos/colesterol si:

Usted tiene un historial de:

- Ataques cardíacos previos
- Diabetes mellitus
- Alta tensión arterial
- Fumar

Ud.:

- Tiene sobrepeso u obesidad
- Es sedentario
- Es un hombre mayor de 44 años
- Es una mujer mayor de 54 años

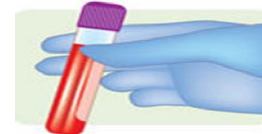
Usted tiene:

- Historial familiar de enfermedades cardíacas tempranas

¿Cómo se trata la dislipidemia o “colesterol alto”?

El tratamiento depende de:

- los niveles de lípidos que usted presente
- el riesgo que usted tenga de un ataque cardíaco
- su salud general



Su médico de cabecera puede recetarle un medicamento hipolipemiante para reducir su colesterol.

LO QUE DEBE HACER

Cambiar su rutina y actividades diarias para reducir su colesterol:

- Perder peso
- Ejercitarse
- Dejar de fumar
- Comer más frutas y vegetales
- Reducir las grasas en su dieta (carnes, leche, huevos, mantequilla, quesos, alimentos procesados y aperitivos tales como galletas dulces y saladas y papas fritas)
- Tomar sus medicamentos tal y como sean prescritos
- Informar efectos secundarios de la medicación
 - ⇒ Con frecuencia se informa de dolores musculares que pueden, o no, ser debidos a su medicamento
- Realizarse las pruebas de sangre según la recomendación de su equipo médico

