PostScRxipt – PrimaRxy Care

May 2007

SIGN CARDIOVSCULAR GUIDELINES: The new guidelines, published in February, are the first to have patient versions. Some of the main primary care prescribing headlines are listed below. Each guideline will be reviewed by the Heart Managed Clinical Network and changes made to the NHSGGC guidelines. Review groups are being set up and updated versions of the guidelines are likely to be issued in the autumn. Until then, the existing guidelines for blood pressure, antiplatelets, heart failure and cholesterol management remain Board policy.

GGC ANTIPLATELET GUIDELINES: The only change to local guidelines at present is an increase to the recommended duration of treatment for clopidogrel after insertion of drug eluting stent to one year. Work is ongoing to identify suitable methods for ensuring the treatment is stopped appropriately.

93: ACS:

- All patients should be maintained on long term aspirin.
- Statin therapy should be started before discharge.
- Patients with unstable angina, myocyte necrosis or clinical MI should receive long term beta blocker and ACE inhibitor.

95: CHF:

- ACE inhibitors should be considered in all patients with heart failure due to LVSD.
  - Patients intolerant of ACEI should be considered for an A2RA.
- All patients with heart failure due to LVSD should be started on beta blocker therapy as soon as their condition is stable.
- Diuretic therapy should be considered for patients with oedema or dyspnoea.
- Patients with moderate to severe heart failure due to LVSD should be considered for spironolactone after specialist advice.

96: STABLE ANGINA:

- Beta blockers should be used as first line therapy for symptom relief.
  - Patients intolerant of beta blockers should be treated with rate limiting calcium channel blockers, nitrates or nicorandil.
- Sublingual GTN should be used for the immediate relief of angina and before performing activities known to induce it.
- Patients with CHD should be given clear advice on how to self medicate with GTN to relieve angina symptoms.
- When adequate symptom control is not achieved with beta blockers a calcium channel blocker should be added.
- Patients not controlled on maximum therapeutic doses of two drugs should be considered for referral to a cardiologist.
- All patients with stable angina due to atherosclerotic disease should receive long term standard aspirin and statin therapy.
- All patients with stable angina should be considered for ACE inhibitor treatment.

CONTROLLED DRUGS (CDs): HDL (2007)12 contains guidance on the safer management of CDs. Each Health Board area must appoint an Accountable Officer (AO) who will be responsible for:

- ensuring systems are in place to routinely monitor the management and use of CDs,
- ensuring there are systems for safe and legal disposal of CDs,
- inspecting a random sample of relevant premises every year,
- investigating concerns or incidents.

The AO role will cover all care sectors in NHSGGC and link with other agencies involved in the prescribing, dispensing and management of CDs. More detail will follow as the role and procedures become clearer.

CALCIPOTRIOL: Dovonex® ointment has been discontinued. The cream and scalp solutions remain available. Patients receiving the ointment formulation could be transferred to the cream where suitable. Those patients who need an ointment formulation could be switched to the other Formulary vitamin D analogue, calcitriol (Silkis®) ointment and monitored for effectiveness.

SIGN 97: RISK ESTIMATION AND PREVENTION OF CARDIOVASCULAR DISEASE

Recommended Interventions, Goals and Follow Up Based on Cardiovascular Risk Assessment

Cardiovascular risk	Lifestyle	Drug Therapy	Treatment goals	Follow up
CVD risk clinically determined ≥20% **Secondary prevention** (previous angina, MI, angioplasty, CABG, TIA, iscahemic stroke, PVD or certain genetic lipid disorders or patients aged over 40 with diabetes).	Intensive lifestyle advice on a cardioprotective dietary pattern with dietitian, physical activity and smoking cessation interventions. Lifestyle advice should be given simultaneously with drug treatment.	In all patients: • an ACE inhibitor • aspirin or other antiplatelet if not tolerated / contraindicated • intensive statin therapy. Following MI: • a beta blocker. With hypertension (≥140/90mmHg or ≥130 / 80mmHg in patients with diabetes with complications or renal disease and end organ damage): • antihypertensive drug therapy.	Aspirin: lifetime treatment with 75mg / day. Lipids: intensive lipid lowering therapy. BP: treat to reduce to <140mmHg systolic and/or <90mmHg diastolic.	Risk factor monitoring every three to six months.
CVD risk calculated ≥20% **Primary prevention**	Intensive lifestyle advice on a cardioprotective dietary pattern with dietitian, physical activity and smoking cessation interventions. Lifestyle advice should be given simultaneously with drug treatment.	• aspirin • 40mg simvastatin (or equivalent dose of pravastatin if simvastatin contraindicated by concomitant use of medications that influence cytochrome P450 metabolism) • antihypertensive drug therapy in patients with hypertension.	Aspirin: lifetime treatment with 75mg daily. Lipids: lifetime treatment with simvastatin 40mg. BP: treat to reduce to <140mmHg systolic and/or <90mmHg diastolic.	Risk factor monitoring every six to twelve months.
CVD risk 10 – 20% Primary prevention	Specific individualised lifestyle advice on cardioprotective dietary pattern, physical activity and smoking cessation given by primary health care team for three to six months before initiating drug treatment.	Drug therapy indicated for people with extreme risk factor levels. (TC >8mmol/l or BP ≥160/100mmHg; these risk factors should be treated and patients considered for drug therapy to reduce other modifiable risk factors and therefore global risk)		Cardiovascular risk assessment every one to five years depending on clinical circumstances.
CVD risk <10% Primary prevention	General lifestyle advice on a cardioprotective dietary pattern, physical activity and smoking cessation.	Non-pharmacological approach to treating multiple risk factors.	Lifestyle advice aimed at reducing cardiovascular risk.	Further cardiovascular risk assessment in five years.

There are no clinical trials which have evaluated the relative and absolute clinical benefits of cholesterol lowering to different total and LDL cholesterol targets in relation to clinical events.

√ The existing cholesterol target of <5mmol/l in individuals with established symptomatic cardiovascular disease should be regarded as the minimum standard of care.

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