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Lipid Management Protocol

RISK CATEGORIES	GOALS FOR THERAPY	CLINICAL MANAGEMENT INTERVENTIONS	LIFESTYLE MODIFICATIONS
Evaluate for ten (10) years CVD risk. Risk Factors include: • Smoking • Hypertension • Dyslipidemia • Low HDL (Exclusive of LDL) • Diabetes • Obesity • Family History • Age Men ≥ 45 Women ≥ 55 Metabolic Syndrome*		***Initial Assessment:*** • Assess fasting lipid panel (FLP) for baseline. LDL is primary focus. • If LDL-C cannot be calculated due to elevated triglyceride level, order LDL-C direct measurement or calculate Non-HDL cholesterol. • FLP within 24 hours of hospitalization for an acute event and recheck FLP in 12 weeks. • Periodically recheck FLP thereafter until goal values are met. • Consider fasting glucose on all initial protocols and prn.	***Recommendations*** • Encourage weight loss/ management. • Promote increased daily physical activity. • Referral for medical nutrition therapy (covered by most payers) - Limit diet to <7% saturated fats and <200 mg/dL of cholesterol from total calories. - Increased consumption of monounsaturated fatty acids (olive/ peanut/ canola oils, nuts/peanut butter, avocado, olives). - Include 6 oz. of fish/wk, specifying tuna, herring or salmon or 1000 mg fish oil per day. - Encourage increased consumption of complex carbohydrates. - Encourage decreased consumption of simple carbohydrates. - Encourage increased consumption of fiber.
RISK CATEGORIES 0-1 Low Risk (<10% in 10 yrs)	LDL<160 and Non-HDL<190 Ideal <130 and Non-HDL<160	• If LDL is ≥ 130 mg/dL (Baseline or on treatment) start or intensify lipid lowering therapy to reach goal (statin preferred). (If patient is hospitalized, start statin.)	
2 + Moderate Risk (10 - 20% in 10 yrs)	LDL<130 and Non-HDL<160 Ideal<100 and Non-HDL<130 *Advise 30-40% reduction*	• If LDL 100-129 mg/dL (Baseline or on treatment): - Start lipid lowering therapy (statin preferred). - Consider combined drug therapy (statin + fibrate or niacin if low HDL or high TG). **Preferred fibrate is fenofibrate (Tricor or Lofibra) with lower dose statin.**	

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High Risk or CHD equivalent (≥ 20% risk in 10 yrs) ***Metabolic Syndrome *(3 of the following):*** *** Fasting Glucose ≥100** *** Abdominal Obesity *Men - Waist circumference* > 102 cm /40 in.** ***Women - Waist circumference* > 88 cm /35 in.** *** Blood Pressure ≥ 130/85** *** Triglycerides ≥ 150** *** HDL** **Men < 40** **Women < 50**	**LDL<70 and Non-HDL<100** ***Advise 30-50% reduction***	• If LDL 100-129 mg/dL (Baseline or on treatment): - Start lipid lowering therapy (statin preferred). - Consider combined drug therapy (statin + fibrate or niacin if low HDL or high TG). **Preferred fibrate is fenofibrate (Tricor or Lofibra) with lower dose statin.** **High Triglycerides Treatment Options:** • If TG > 500 mg/dL: - Treat TG first to prevent pancreatitis. - Initiate fibrate and lifestyle management. - Initiate/resume lipid-lowering therapy (statin preferred). - **Tricor or Lofibra is preferred fibrate in combination with lower dose statin.** • If TG 200-499 mg/dL: - Start fibrate or niacin. - Initiate lifestyle management - **Tricor or Lofibra is preferred fibrate in combination with lower dose statin.** - If triglycerides >150 consider FBS - Aggressive treatment of diabetes - Consider Actos (pioglitazone) **Low HDL Therapy Options:·** • If HDL ≤40 mg/dL for men or ≤50 mg/dL for women: - First attain LDL goal - Consider the addition of Niaspan Consider fibrates - Consider Actos (pioglitazone) in diabetes - Intensify weight management and physical activity.	

Note: This practitioner's tool was developed to provide guidance to providers and is not intended to replace or preclude clinical judgement.

References: Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation and Treatment of High Cholesterol in Adults (ATP III) NIH Publication No. 02 - 5215 September 2002 Cardiovascular Associates of Northern Wisconsin Clinical Based Guidelines, David K. Murdock, M.D. NCEP Report: Implications of Recent Clinical Trials for the national Cholesterol Education Program ATP III Guideline Circulation. 2004; 110:227-234

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