



**XXIX  
CONGRESSO  
NAZIONALE  
ANCE**

10 – 13 Ottobre 2019  
Centro Congressi  
Hilton Sorrento Palace  
Sorrento (NA)





**XXIX  
CONGRESSO  
NAZIONALE  
ANCE**

La gestione  
dell'ipercolesterolemia  
nel paziente a basso  
rischio cardiovascolare

Giancarlo D'Innocente  
Medico di  
medicina generale  
ASL Pescara





# Considerazione

La gestione del soggetto con ipercolesterolemia ed a basso rischio cardiovascolare, **spesso asintomatico**, è di competenza quasi esclusiva del medico di medicina generale

Il paziente a basso rischio cardiovascolare può sviluppare nel tempo **eventi cardiovascolari**

Una corretta gestione **migliora la loro qualità di vita** riducendone gli eventi a distanza e, di conseguenza, **riducendo i costi per il Servizio Sanitario Nazionale**



È necessario definire  
il rischio cardiovascolare



Per la valutazione del  
rischio cardiovascolare facciamo  
riferimento alle Linee-Guida  
ESC/EAS del 2019



# **2019 ESC/EAS Guidelines for the management of dyslipidaemias: *lipid modification to reduce cardiovascular risk***

**The Task Force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and European Atherosclerosis Society (EAS)**



# Il rischio cardiovascolare inizia con la nascita

## 4.1.1 Rationale for assessing total cardiovascular disease risk

All current guidelines on the prevention of ASCVD in clinical practice recommend the assessment of total CVD risk. Prevention of ASCVD in a given person should relate to his or her total CV risk: the higher the risk, the more intense the action should be.

Più alto è il rischio cardiovascolare: più intensa dovrebbe essere l'azione

## Il rischio cardiovascolare varia nei soggetti dei vari Stati Europei

... extensively reviewed (Supplementary Table 1 in the Supplementary Data). Most guidelines use one of these risk assessment systems.<sup>6–8</sup> Ideally, risk charts should be based on country-specific cohort data. These are not available for most countries. The SCORE (Systematic Coronary Risk Estimation) system can be recalibrated for use in different populations by adjusting for secular changes in CVD mortality and risk factor prevalence. Calibrated country-specific versions are available for many European countries and can be found at [http://www.who.int/diabetes/cvd\\_risk\\_factor/score](http://www.who.int/diabetes/cvd_risk_factor/score)



## Risk estimation charts for different countries

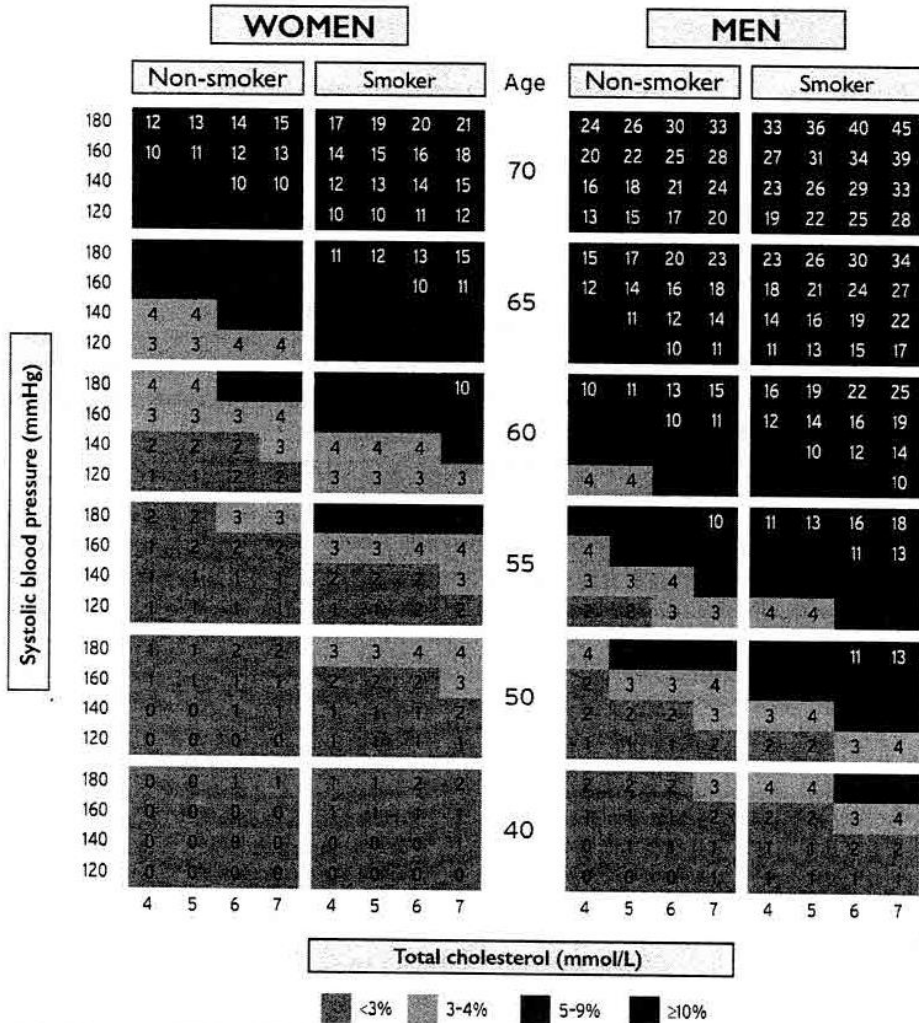
The **low-risk charts** should be considered for use in Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, **Italy**, Luxembourg, Netherlands, Norway, Malta, Portugal, Slovenia, Spain, Sweden, Switzerland, and the UK.

The **high-risk charts** should be considered for use in Albania, Algeria, Armenia, Bosnia and Herzegovina, Croatia, Czech Republic, Estonia, Hungary, Latvia, Lebanon, Libya, Lithuania, Montenegro, Morocco, Poland, Romania, Serbia, Slovakia, Tunisia, and Turkey.

Some countries have a cardiovascular disease mortality rate  $>350/100$  000, and the **high-risk chart may underestimate risk**. These are Azerbaijan, Belarus, Bulgaria, Egypt, Georgia, Kazakhstan, Kyrgyzstan, North Macedonia, Republic of Moldova, Russian Federation, Syria, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan.

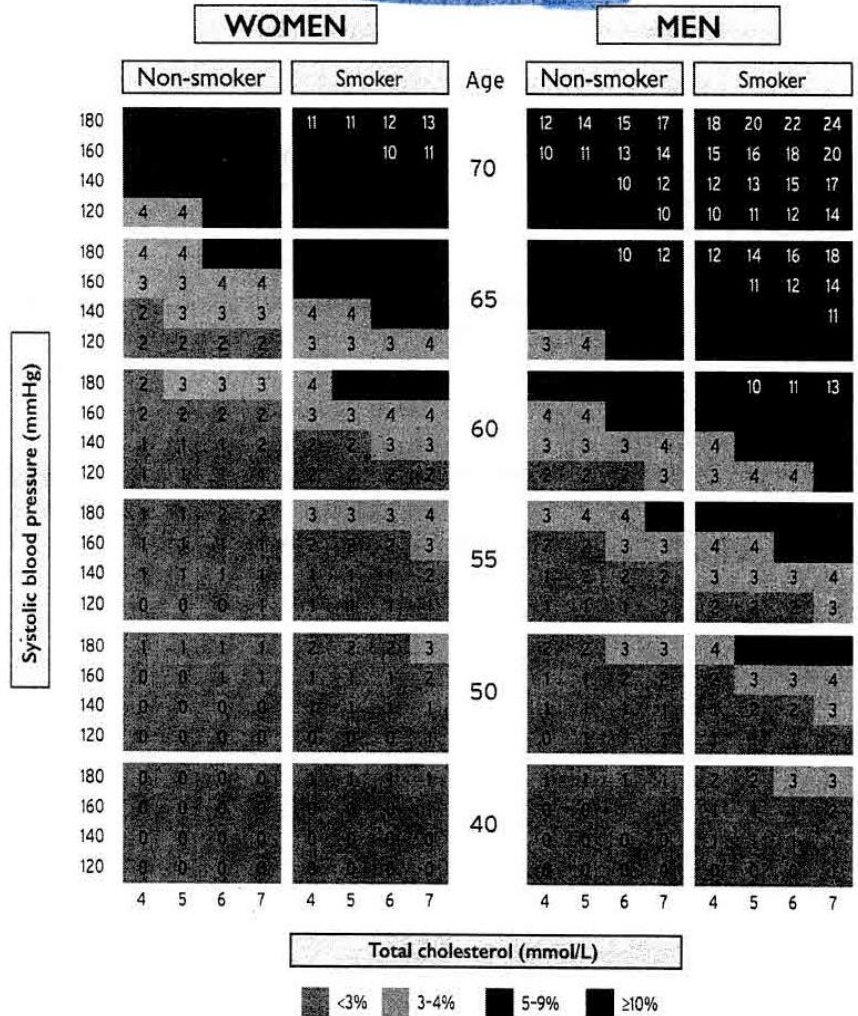
**SCORE Cardiovascular Risk Chart**  
10-year risk of fatal CVD

High-risk regions of Europe



**SCORE Cardiovascular Risk Chart**  
10-year risk of fatal CVD

Low-risk regions of Europe





## Relazione tra:

rischio SCORE di evento cardiovascolare fatale a 10 anni e  
rischio CUORE di evento cardiovascolare, fatale o non fatale a 10 anni

SCORE	CUORE
Altissimo $\geq 10\%$	$\geq 30\%$
Alto $\geq 5\% < 10\%$	$\geq 20\% < 30\%$
Moderato $\geq 1\% < 5\%$	$\geq 5\% < 20\%$
Basso $< 1\%$	$< 5\%$



I fattori considerati per la valutazione del rischio  
con la carta SCORE sono:

Età, sesso, fumo, pressione arteriosa sistolica, colesterolo totale



**Table 5 Intervention strategies as a function of total cardiovascular risk and untreated low-density lipoprotein cholesterol levels**

	Total CV risk ( SCORE) % Untreated LDL-C levels						
	<1.4 mmol/L (55 mg/dl)	1.4 to <1.8 mmol/L (<70 mg/dl)	1.8 mmol/L to <2.6 mmol/L (70 to <100mg/dl)	2.6 mmol/L to <3 mmol/L (100 to 116 mg/dl)	3 mmol/L to <4.9 mmol/L (116 to <190mg/dl)	>4.9 mmol/L (>190 mg/dl)	
Primary prevention	<b>lifestyle advice</b>	<b>lifestyle advice</b>	<b>lifestyle advice</b>	<b>lifestyle advice</b>	Lifestyle intervention, consider adding drug if uncontrolled	<b>lifestyle intervention and concomitant drug intervention</b>	
	CLASS/LEVEL C	IC	NIC	II/C	IIa/A	IIa/A	

CLASSI  
DI  
RACCOMANDAZIONI

Classes	Definition	Wording to use
Classe I	Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective	Is recommended or indicated
Classe II	Conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of the given treatment or procedure	
Classe IIa	Weight of evidence/opinion is in favour of usefulness/efficacy	Should be considered
Classe IIb	usefulness/efficacy il less well established by evidence/opinion	May be considered
Classe III	Evidence or general agreement that the given treatment or procedure is not usefull/effective, and in some cases may be harmful	Is not recommended

**Table 4 Cardiovascular risk categories**

**Very-high-risk**

People with any of the following:  
Documented ASCVD, either clinical or unequivocal on imaging. Documented ASCVD includes previous ACS (MI or unstable angina), stable angina, coronary revascularization (PCI, CABG, and other arterial revascularization procedures), stroke and TIA, and peripheral arterial disease. Unequivocally documented ASCVD on imaging includes those findings that are known to be predictive of clinical events, such as significant plaque on coronary angiography or CT scan (multivessel coronary disease with two major epicardial arteries having >50% stenosis), or on carotid ultrasound.  
DM with target organ damage,<sup>a</sup> or at least three major risk factors, or early onset of T1DM of long duration (>20 years).  
Severe CKD (eGFR <30 mL/min/1.73 m<sup>2</sup>).  
A calculated SCORE  $\geq$ 10% for 10-year risk of fatal CVD.  
FH with ASCVD or with another major risk factor.

**High-risk**

People with:  
Markedly elevated single risk factors, in particular TC >8 mmol/L (>310 mg/dL), LDL-C >4.9 mmol/L (>190 mg/dL), or BP  $\geq$ 180/110 mmHg.  
Patients with FH without other major risk factors.  
Patients with DM without target organ damage,<sup>a</sup> with DM duration  $\geq$ 10 years or another additional risk factor.  
Moderate CKD (eGFR 30–59 mL/min/1.73 m<sup>2</sup>).  
A calculated SCORE  $\geq$ 5% and <10% for 10-year risk of fatal CVD.

**Moderate-risk**

Young patients (T1DM <35 years; T2DM <50 years) with DM duration <10 years, without other risk factors. Calculated SCORE  $\geq$ 1% and <5% for 10-year risk of fatal CVD.

**Low-risk**

Calculated SCORE <1% for 10-year risk of fatal CVD.

Basso rischio  
cardiovascolare

## 4.2 Risk levels

A total CV risk estimate is part of a continuum. The cut-off points that are used to define high-risk are, in part, both arbitrary and based on the risk levels at which benefit is evident in clinical trials. In clinical practice, consideration should be given to practical issues in relation to the local healthcare systems.

Low-risk people should be given advice to help them maintain this status.



Levels of evidence	
Level of evidence <b>A</b>	Data derived from multiple randomized clinical trials or meta-analyses
Level of evidence <b>B</b>	Data derived from a single randomized clinical trial or large non-randomized studies
Level of evidence <b>C</b>	Consensus of opinion of the experts and/or small studies, retrospective studies, registries



## Recommendations for cardiovascular imaging for risk assessment of atherosclerotic cardiovascular disease

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
Arterial (carotid and/or femoral) plaque burden on arterial ultrasonography should be considered as a risk modifier in individuals at low or moderate risk. <sup>29,30</sup>	<b>IIa</b>	<b>B</b>
CAC score assessment with CT should be considered as a risk modifier in the CV risk assessment of asymptomatic individuals at low or moderate risk. <sup>14–16,24,26</sup>	<b>IIa</b>	<b>B</b>

CAC = coronary artery calcium; CT = computed tomography; CV = cardiovascular.

©ESC 2019



## Recommendations for cardiovascular disease risk estimation

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
Total risk estimation using a risk estimation system such as SCORE is recommended for asymptomatic adults >40 years of age without evidence of CVD, DM, CKD, familial hypercholesterolaemia, or LDL-C >4.9 mmol/L (>190 mg/dL).	I	C
It is recommended that high- and very-high-risk individuals are identified on the basis of documented CVD, DM, moderate-to-severe renal disease, very high levels of individual risk factors, FH, or a high SCORE risk. It is recommended that such patients are considered as a priority for advice and management of all risk factors.	I	C
Risk scores developed for the general population are not recommended for CV risk assessment in patients with DM or FH.	III	C

Primary prevention

<1, low risk



Nei soggetti a basso rischio cardiovascolare si raccomanda un target di LDL-Colesterolo < 116 mg/dl (raccomandazione di classe IIb e di livello A)

### Recommendations for treatment goals for low-density lipoprotein cholesterol

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
In secondary prevention for patients at very-high risk, <sup>c</sup> an LDL-C reduction of $\geq 50\%$ from baseline <sup>d</sup> and an LDL-C goal of <1.4 mmol/L (<55 mg/dL) are recommended. <sup>33–35,119,120</sup>	I	A
In primary prevention for individuals at very-high risk but without FH, <sup>c</sup> an LDL-C reduction of $\geq 50\%$ from baseline <sup>d</sup> and an LDL-C goal of <1.4 mmol/L (<55 mg/dL) are recommended. <sup>34–36</sup>	I	C
In primary prevention for individuals with FH at very-high risk, an LDL-C reduction of $\geq 50\%$ from baseline and an LDL-C goal of <1.4 mmol/L (<55 mg/dL) should be considered.	IIa	C
For patients with ASCVD who experience a second vascular event within 2 years (not necessarily of the same type as the first event) while taking maximally tolerated statin-based therapy, an LDL-C goal of <1.0 mmol/L (<40 mg/dL) may be considered. <sup>119,120</sup>	IIb	B
In patients at high risk, <sup>c</sup> an LDL-C reduction of $\geq 50\%$ from baseline <sup>d</sup> and an LDL-C goal of <1.8 mmol/L (<70 mg/dL) are recommended. <sup>34,35</sup>	I	A
In individuals at moderate risk, <sup>c</sup> an LDL-C goal of <2.6 mmol/L (<100 mg/dL) should be considered. <sup>34</sup>	IIc	A
In individuals at low risk, <sup>c</sup> an LDL-C goal <3.0 mmol/L (<116 mg/dL) may be considered. <sup>36</sup>	IIb	A

### **5.3.3 High-density lipoprotein cholesterol and risk of atherosclerosis**

The inverse association between plasma HDL-C and the risk of ASCVD is among the most consistent and reproducible associations in observational epidemiology.<sup>45,60</sup> In contrast, Mendelian randomization studies do not provide compelling evidence that HDL-C is causally associated with the risk of ASCVD.<sup>49,61,62</sup> However, this evidence must be interpreted with caution because most genetic variants associated with HDL-C are also associated with directionally opposite changes in TGs, LDL-C, or both, thus making estimates of the effect of HDL-C on the risk of ASCVD very difficult using the Mendelian randomization study design.

### 7.3 Influence of lifestyle on high-density lipoprotein cholesterol levels

Weight reduction increases HDL-C levels; a 0.01 mmol/L (0.4 mg/dL) increase is observed for every kilogram decrease in body weight when weight reduction has stabilized. Aerobic physical activity, such as 25–30 km of brisk walking per week (or any equivalent activity), may increase HDL-C levels by 0.08–0.15 mmol/L (3.1–6 mg/dL).<sup>169</sup> Smoking cessation may also contribute to HDL-C elevation, provided that weight gain is prevented.<sup>163</sup>



## Recommendations for lipid analyses for cardiovascular disease risk estimation

### Recommendations

TC is to be used for the estimation of total CV risk by means of the SCORE system.

HDL-C analysis is recommended to further refine risk estimation using the online SCORE system.

LDL-C analysis is recommended as the primary lipid analysis method for screening, diagnosis, and management.

TG analysis is recommended as part of the routine lipid analysis process.

LDL-C analysis is recommended for risk assessment, particularly in patients with high TC.

Class <sup>a</sup>	Level <sup>b</sup>
I	C
II	C
III	C
IV	C
V	C

RACCOMANDAZIONI	CLASSE <sup>a</sup>	LIVELLO <sup>b</sup>
Si raccomanda di utilizzare il dosaggio del Col-LDL come analisi primaria dei lipidi.	I	C
Il dosaggio dei TG aggiunge informazioni al rischio ed è indicato per la diagnosi e la scelta del trattamento.	I	C
Si raccomanda il dosaggio del Col-HDL prima dell'inizio del trattamento.	I	C
Si dovrebbe raccomandare il dosaggio del Col-non-HDL per l'ulteriore caratterizzazione delle iperlipidemie combinate e delle dislipidemie nel diabete, sindrome metabolica e malattia renale cronica.	IIa	C
Si dovrebbe raccomandare il dosaggio di Apo B per l'ulteriore caratterizzazione delle iperlipidemie combinate e delle dislipidemie nel diabete, sindrome metabolica e malattia renale cronica.	IIa	C
Si dovrebbe raccomandare il dosaggio di Lp(a) in casi selezionati ad alto rischio ed in soggetti con storia familiare di patologia CV.	IIa	C
Il dosaggio del CT dovrebbe essere considerato, ma di solito non è sufficiente per la caratterizzazione della dislipidemia prima dell'inizio del trattamento.	IIa	C
<sup>a</sup> Classe di raccomandazione. <sup>b</sup> Livello di evidenza. Apo = apolipoproteina; CV = cardiovascolare; Col-HDL = colesterolo a lipoproteine ad alta densità; Col-LDL = colesterolo a lipoproteine a bassa densità; Lp = lipoproteina; MetS= sindrome metabolica; CT = colesterolo totale; TG = trigliceridi.		

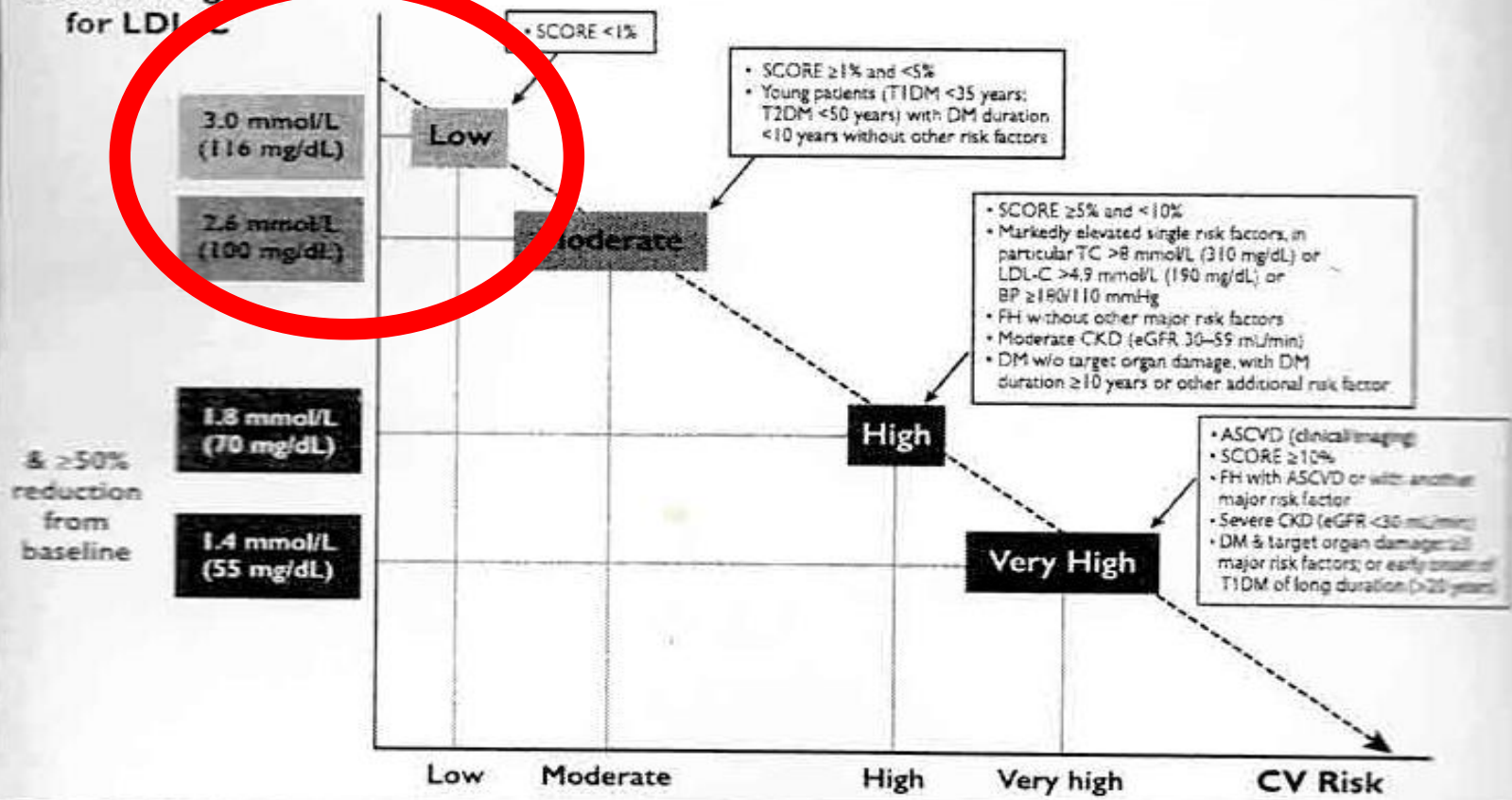
*Tabella 2. Raccomandazioni per la caratterizzazione delle dislipidemie prima del trattamento.*



**Table 7 Treatment targets and goals for cardiovascular disease prevention**

<b>Smoking</b>	No exposure to tobacco in any form.
<b>Diet</b>	Healthy diet low in saturated fat with a focus on wholegrain products, vegetables, fruit, and fish.
<b>Physical activity</b>	3.5–7 h moderately vigorous physical activity per week or 30–60 min most days.
<b>Body weight</b>	BMI 20–25 kg/m <sup>2</sup> , and waist circumference <94 cm (men) and <80 cm (women).
<b>Blood pressure</b>	<140/90 mmHg. <sup>a</sup>
<b>LDL-C</b>	<p><b>Very-high risk in primary or secondary prevention:</b></p> <p>A therapeutic regimen that achieves ≥50% LDL-C reduction from baseline<sup>b</sup> and an LDL-C goal of &lt;1.4 mmol/L (&lt;55 mg/dL). No current statin use: this is likely to require high-intensity LDL-lowering therapy. Current LDL-lowering treatment: an increased treatment intensity is required.</p> <p><b>High risk:</b> A therapeutic regimen that achieves ≥50% LDL-C reduction from baseline<sup>b</sup> and an LDL-C goal of &lt;1.8 mmol/L (&lt;70 mg/dL).</p> <p><b>Moderate risk:</b></p> <p>A goal of &lt;2.6 mmol/L (&lt;100 mg/dL).</p> <p><b>Low risk:</b></p> <p>A goal of &lt;3.0 mmol/L (&lt;116 mg/dL).</p>
<b>Triglycerides</b>	No goal, but <1.7 mmol/L (<150 mg/dL) indicates lower risk and higher levels indicate a need to look for other risk factors.

# Treatment goal for LDL-C





## Consigli sullo stile di vita ai pazienti ipercolesterolemici ed a basso rischio cardiovascolare per ridurre il colesterolo totale e il LDL-Colesterolo

**Table 8 Impact of specific lifestyle changes on lipid levels**

	Magnitude of the effect	Level	Reference
<b>Lifestyle interventions to reduce TC and LDL-C levels</b>			
Avoid dietary trans fats	++	A	129,138
Reduce dietary saturated fats	++	A	129,139
Increase dietary fibre	++	A	140,141
Use functional foods enriched with phytosterols	++	A	142,143
Use red yeast rice nutraceuticals	++	A	144–146
Reduce excessive body weight	++	A	147,148
Reduce dietary cholesterol	+	B	149,150
Increase habitual physical activity	+	β	151



## Consigli sullo stile di vita ai pazienti ipercolesterolemici ed a basso rischio cardiovascolare per ridurre I trigliceridi

Lifestyle interventions to reduce TG-rich lipoprotein levels			
Reduce excessive body weight	+	A	147,148
Reduce alcohol intake	+++	A	152,153
Increase habitual physical activity	++	A	151,154
Reduce total amount of dietary carbohydrates	++	A	147,155
Use supplements of n-3 polyunsaturated fats	++	A	156,157
Reduce intake of mono- and disaccharides	++	B	158,159
Replace saturated fats with mono- or polyunsaturated fats	+	B	129,137



## Consigli sullo stile di vita ai pazienti ipercolesterolemici ed a basso rischio cardiovascolare per aumentare l'HDL-Colesterolo

### Lifestyle interventions to increase HDL-C levels

Avoid dietary trans'fats	++	A	129,160
Increase habitual physical activity	+++	A	151,161
Reduce excessive body weight	++	A	147,148
Reduce dietary carbohydrates and replace them with unsaturated fats	++	A	147,162
Modest consumption in those who take alcohol may be continued	++	B	153
Quit smoking	+	B	163

**Table 9 Food choices to lower low-density lipoprotein cholesterol and improve the overall lipoprotein profile**

	To be preferred	To be used in moderation	To be chosen occasionally in limited amounts
Cereals	Wholegrains	Refined bread, rice, and pasta, biscuits, corn flakes	Pastries, muffins, pies, croissants
Vegetables	Raw and cooked vegetables	Potatoes	Vegetables prepared in butter or cream
Legumes	Lentils, beans, fava beans, peas, chickpeas, soybean		
Fruit	Fresh or frozen fruit	Dried fruit, jelly, jam, canned fruit, sorbets, ice lollies/popsicles, fruit juice	
Sweets and sweeteners	Non-caloric sweeteners	Sucrose, honey, chocolate, sweets/candies	Cakes, ice creams, fructose, soft drinks
Meat and fish	Lean and oily fish, poultry without skin	Lean cuts of beef, lamb, pork, and veal, seafood, shellfish	Sausages, salami, bacon, spare ribs, hot dogs, organ meats
Dairy food and eggs	Skimmed milk and yoghurt	Low-fat milk, low-fat cheese and other milk products, eggs	Regular cheese, cream, whole milk and yoghurt
Cooking fat and dressings	Vinegar, mustard, fat-free dressings	Olive oil, non-tropical vegetable oils, soft margarines, salad dressing, mayonnaise, ketchup	Trans fats and hard margarines (better to avoid them), palm and coconut oils, butter, lard, bacon fat
Nuts/seeds		All, unsalted (except coconut)	Coconut
Cooking procedures	Grilling, boiling, steaming	Stir-frying, roasting	Frying

Il paziente ipercolesterolemico ed a basso rischio cardiovascolare non deve incrementare il proprio peso corporeo, dovrebbe mantenersi in un range di BMI 20 – 25.

L'obesità, soprattutto quella androide, aumenta la dislipidemia

#### **7.4.1 Body weight and physical activity**

Since overweight, obesity, and—in particular—abdominal adiposity often contribute to dyslipidaemia, caloric intake should be reduced and energy expenditure increased in those with excessive weight and/or abdominal adiposity.

La riduzione del peso nei soggetti con BMI >25 riduce il rischio cardiovascolare

In the case of excess weight, body weight reduction, even if modest (5–10% of basal body weight), improves lipid abnormalities and favourably affects the other CV risk factors often present in dyslipidaemic individuals.<sup>148</sup> While the beneficial effects of weight reduction on metabolic and surrogate markers have been demonstrated, the benefits of weight loss on mortality and CV outcome are less clear.<sup>175</sup>



Il paziente ipercolesterolemico ed a basso rischio cardiovascolare deve seguire una dieta idonea per mantenere il proprio BMI sui 20 – 25 o per raggiungere tale BMI.

Deve sempre abbinare una idonea, costante, aerobica attività fisica

Weight reduction can be achieved by decreasing the consumption of energy-dense foods, inducing a caloric deficit of 300–500 kcal/day. The intervention should combine diet and exercise; this approach also leads to the greatest improvement in physical performance and quality of life, and mitigates reductions in muscle and bone mass, particularly in older people.<sup>176</sup> It is always appropriate to advise people with dyslipidaemia to engage in regular physical exercise of moderate intensity for  $\geq 30$  min/day, even if they are not overweight.<sup>168</sup>



## **7.5 Dietary supplements and functional foods for the treatment of dyslipidaemias**

Nutritional evaluation of functional foods includes not only the search for clinical evidence of beneficial effects relevant to improved health or the reduction of disease risk, but also the demonstration of good tolerability. Overall, the available evidence on functional foods so far identified in this field is incomplete; the major gap is an absence of diet-based intervention trials of enough duration to be relevant for the natural history of dyslipidaemia and CVD.



Gli integratori alimentari, con diverse evidenze cliniche, **hanno dimostrato benefici effetti sulla salute nella riduzione del rischio cardiovascolare e sono ben tollerati.**

Tuttavia, per alcuni di essi, non ci sono prove disponibili “complete”. Il divario maggiore si ha per l'assenza di studi di intervento dietetico di durata sufficiente per essere rilevanti per la storia naturale di dislipidemia e CVD



## Dietary supplements and functional food:

- .Fitosteroli
- .Monacolina e riso rosso fermentato
- .Fibre
- .Soia
- .Policosanoli e berberina
- .Acidi grassi insaturi



# Monacolina e riso rosso fermentato

## 7.5.2 Monacolin and red yeast rice

In the only available RCT in patients with ASCVD, a partially purified extract of RYR reduced recurrent events by 45%.<sup>146</sup> A clinically relevant hypocholesterolaemic effect (up to a 20% reduction) has been observed with RYR preparations providing an o.d. [once daily (omni die)] dose of 5–10 mg monacolin K.<sup>145</sup> Nutraceuticals containing purified RYR may be considered in people with elevated plasma cholesterol concentrations who do not qualify for treatment with statins in view of their global CV risk. However, there is a clear need for better regulation of RYR supplements. Information regarding the precise composition of these products, the quantities of their components, and their purity should be implemented.<sup>185</sup>



In prevenzione primaria, in assenza di controindicazioni cliniche, nei soggetti ipercolesterolemici con:

- .LDL colesterolo  $>116$  mg/dl e  $<190$  mg/dl
- .si **possono** prescrivere farmaci o integratori alimentari ipocolesterolemizzanti
  
- .LDL colesterolo  $>190$  mg/dl
- .si **devono** prescrivere farmaci ipocolesterolemizzanti



Non prescrivere farmaci ipocolesterolemizzanti, in prevenzione prim

**inappropriatezza prescrittiva per difetto**

(raccomandazione IIa/A)



## Farmaci per il trattamento dell'ipercolesterolemia nella abituale pratica clinica del MMG:

- .Statine
- .Ezetimibe
- .Sequestranti acidi biliari (colestiramina)
- .Fibrati



# Quali farmaci devo prescrivere per abbassare il colesterolo-LDL?

## Recommendations for pharmacological low-density lipoprotein cholesterol lowering

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
It is recommended that a high-intensity statin is prescribed up to the highest tolerated dose to reach the goals set for the specific level of risk. <sup>32,34,38</sup>	I	A
If the goals <sup>c</sup> are not achieved with the maximum tolerated dose of a statin, combination with ezetimibe is recommended. <sup>33</sup>	I	B
If a statin-based regimen is not tolerated at any dosage (even after rechallenge), ezetimibe should be considered. <sup>197,265,353</sup>	IIa	C
If a statin-based regimen is not tolerated at any dosage (even after rechallenge), a PCSK9 inhibitor added to ezetimibe may also be considered. <sup>197,265,353</sup>	IIb	C
If the goal <sup>c</sup> is not achieved, statin combination with a bile acid sequestrant may be considered.	IIc	C



# CONCLUSIONI

Il paziente ipercolesterolemico a basso rischio cardiovascolare ha una scarsa percezione delle sue condizioni cliniche.

Il MMG ha il compito di convincerlo a mantenere o a seguire un corretto stile di vita ed ad osservare, se indicata, la terapia farmacologica e gli accertamenti medici.

Per far ciò il MMG deve saper ascoltare il paziente, essere convinto di ciò che dice e, soprattutto, deve saper trasmettere tale convinzione al paziente



# CONCLUSIONI

Saper ben comunicare per avere:

- .Maggiore aderenza ai consigli sullo stile di vita
- .Maggiore aderenza alla eventuale terapia
- .Riduzione degli eventi cardiovascolari

Cerca il tuo paziente a basso  
rischio cardiovascolare





*Grazie dell'attenzione*