Table 1

<table>
<thead>
<tr>
<th>Compelling Indications for Individual Drug Classes</th>
<th>Initial Therapy Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>THIAZ, BB, ACEI, ARB, ALDO ANT</td>
</tr>
<tr>
<td>Post Myocardial Infarction</td>
<td>BB, ACEI, ALDO ANT, ARB</td>
</tr>
<tr>
<td>High CVD Risk</td>
<td>THIAZ, BB, ACEI, CCB, ARB</td>
</tr>
<tr>
<td>Diabetes</td>
<td>THIAZ, BB, ACEI, ARB, CCB</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>ACEI, ARB</td>
</tr>
<tr>
<td>Recurrent Stroke Prevention</td>
<td>THIAZ, ACEI</td>
</tr>
</tbody>
</table>

Key: THIAZ = thiazide diuretic, ACEI = angiotensin converting enzyme inhibitor, ARB = angiotensin receptor blocker, BB = beta blocker, CCB = calcium channel blocker, ALDO ANT = aldosterone antagonist
Lipid Management

- Total cholesterol <200 and HDL >60, triglycerides <200
- Determine if lipid lowering therapy is needed (Use Table 2)
- Initiate therapeutic lifestyle changes or drug therapy (For protocol see Figures 2 and 3)

### LDL Cholesterol Goals and Cutpoints for Therapeutic Lifestyle Changes (TLC) and Drug Therapy in Different Risk Categories

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>LDL Goal</th>
<th>LDL Level at Which to Initiate TLC</th>
<th>LDL Level at Which to Consider Drug Therapy**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Risk:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHD or CHD Risk Equivalents (10 year risk &gt;20%)*</td>
<td>&lt;100 mg/dL</td>
<td>≥100 mg/dL</td>
<td>≥100 mg/dL (&lt;100 mg/dL: consider drug options)**</td>
</tr>
<tr>
<td></td>
<td>(optional goal: &lt;70)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Moderately High Risk:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2+ Risk Factors (10 year risk 10-20%)*</td>
<td>&lt;130 mg/dL</td>
<td>≥130 mg/dL</td>
<td>≥130 mg/dL (100-129 mg/dL consider drug options)</td>
</tr>
<tr>
<td></td>
<td>(optional goal: &lt;100)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Moderate Risk:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2+ risk factors (10 year risk &lt;10%)*</td>
<td>&lt;130 mg/dL</td>
<td>≥130 mg/dL</td>
<td>≥160 mg/dL</td>
</tr>
<tr>
<td><strong>Lower Risk:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Risk Factor</td>
<td>&lt;160 mg/dL</td>
<td>≥160 mg/dL</td>
<td>≥190 mg/dL (160-189 mg/dL: LDL lowering drug Optional)</td>
</tr>
</tbody>
</table>


** When LDL-lowering drug therapy is employed, it is advised that intensity of therapy be sufficient to achieve at least a 30% to 40% reduction in LDL-C levels.

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**Model of Steps in Therapeutic Lifestyle Changes (TLC)**

**Begin Lifestyle Therapies**
- Emphasize reduction in saturated fat and cholesterol
- Encourage moderate physical activity
- Consider referral to dietician

**Evaluate LDL response**
- If LDL goal not achieved, intensify LDL lowering tx
- Reinforce reduction in saturated fat and cholesterol
- Consider adding plant stanols/sterols
- Consider referral to dietician

**Q 4-6 mos**
- Monitor adherence to TLC

**After Initiating Therapy – Progression of Drug Therapy in Primary Prevention**

**Initiate LDL Lowering Drug Therapy**
- Start statin or bile acid sequestrant or nicotinic acid

**If LDL Goal Not Achieved, Intensify LDL Lowering Therapy**
- Consider higher dose of statin or combination therapy

**Q 4-6 mos**
- Monitor Response and Adherence To Therapy

**Dietary and Physical Activity Assessment**

- Physical activity, of moderate intensity, for at least 30 minutes on most days of the week.
- Decrease cholesterol, saturated fat and trans fatty acids in diet
- Increase fiber

**BMI**

- Achieve and maintain BMI at 18.5 – 24.9 Kg/m²

**Diabetes**

- Initiate appropriate hypoglycemic therapy to A1c <7%

**Chronic Atrial Fibrillation**

- Anticoagulation with INR 2.0 – 3.0

**ASA Therapy**

- 2 or more risk factors and no contraindications – prescribe 81-325 mg/QD

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**REFERENCES:**
- AHA Guidelines for Primary Prevention of Cardiovascular Disease and Stroke: 2002 Update