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EDITORIAL

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Guidelines are not mandates

Just like the 2018 hypertension treatment guidelines, the 2018 Guidelines on the Management of Blood Cholesterol developed by the American College of Cardiology and the American Heart Association (ACC/AHA) have made treatment decisions much more complicated. In this issue of *JFP,* Wójcik and Shapiro summarize the 70-page document to help family physicians and other primary health care professionals use these complex guidelines in everyday practice (see page 206).

The good news is that not much has changed from the 2013 ACC/AHA cholesterol guidelines regarding the treatment of patients with established cardiovascular disease and diabetes mellitus, and those with familial hyperlipidemia—the groups at highest risk for major cardiovascular events. Most of these patients should be treated aggressively, and a target low-density lipoprotein of 70 mg/dL is recommended.

I find the recommendations for adults ages 75 and older and for children and teens to be problematic.

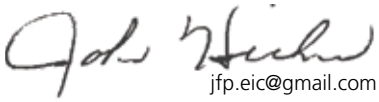
The new guidelines recommend using ezetimibe or a PCSK9 inhibitor if the goal of 70 mg/dL cannot be achieved with a statin alone. There is randomized trial evidence to support the benefit of this aggressive approach. Generic ezetimibe costs about $20 per month,[1] but the PCSK9 inhibitors are about $500 per month,[2,3] so cost may be a treatment barrier for the 2 monoclonal antibodies approved for cardiovascular prevention: evolocumab and alirocumab.

For primary prevention, the new guidelines are much more complicated. They divide cardiovascular risk into 4 tiers depending on the 10-year risk for atherosclerotic cardiovascular disease calculated using the "pooled cohort equation." Treatment recommendations are more aggressive for those at higher risk. Although it intuitively makes sense to treat those at higher risk more aggressively, there is no clinical trial evidence to support this approach's superiority over the simpler approach recommended in the 2013 guidelines.

I find the recommendations for screening and primary prevention in adults ages 75 and older and for children and teens to be problematic. A meta-analysis of 28 studies found no statin treatment benefit for primary prevention in those older than 70.[4] And there are no randomized trials showing benefit of screening and treating children and teens for hyperlipidemia.

On a positive note, most patients do *not* need to fast prior to having their lipids measured.

Read the 2018 cholesterol treatment guideline summary in this issue of *JFP*. But as you do so, remember that guidelines are guidelines; they are not mandates for treatment. You may need to customize these guidelines for your practice and your patients. In my opinion, the simpler 2013 cholesterol guidelines remain good guidelines.



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