



MOLINA HEALTHCARE OF CALIFORNIA

CVD: SECONDARY PREVENTION FOR PATIENTS WITH CORONARY AND OTHER VASCULAR DISEASE GUIDELINE

The American Heart Association (AHA)/ American College of Cardiology (ACC) Secondary Prevention for Patients with Coronary and Other Vascular Disease: 2006 Update Endorsed by the National Heart, Lung and Blood Institute was reviewed and adopted by the Molina Healthcare of California Clinical Quality Management Committee on December 10, 2008 and November 4, 2009.



Clinical Practice Guideline

Secondary Prevention for Patients with Coronary and Other Vascular Disease

Since the 2001 update of the American Heart Association (AHA)/American College of Cardiology (ACC) consensus statement on secondary prevention¹, important evidence from clinical trials has emerged that further supports and broadens the merits of aggressive risk-reduction therapies for patients with established coronary and other atherosclerotic vascular disease, including peripheral arterial disease, atherosclerotic aortic disease, and carotid artery disease. This growing body of evidence confirms that aggressive comprehensive risk factor management improves survival, reduces recurrent events and the need for interventional procedures, and improves quality of life for these patients.

Table 1: AHA/ACC Secondary Prevention for Patients with Coronary and Other Vascular Disease*: 2006 Update

	Intervention Recommendations With Class of Recommendation and Level of Evidence
SMOKING: Goal Complete cessation. No exposure to environmental tobacco smoke.	<ul style="list-style-type: none"> • Ask about tobacco use status at every visit. I (B) • Advise every tobacco user to quit. I (B) • Assess the tobacco user’s willingness to quit. I (B) • Assist by counseling and developing a plan for quitting. I (B) • Arrange follow-up, referral to special programs, or pharmacotherapy (including nicotine replacement and bupropion). I (B) • Urge avoidance of exposure to environmental tobacco smoke at work and home. I (B)
BLOOD PRESSURE CONTROL: Goal <140/90 mm Hg or <130/80 mm Hg if patient has diabetes or chronic kidney disease	For all patients: <ul style="list-style-type: none"> • Initiate or maintain lifestyle modification—weight control; increased physical activity; alcohol moderation; sodium reduction; and emphasis on increased consumption of fresh fruits, vegetables, and low-fat dairy products. I (B) • For patients with blood pressure $\geq 140/90$ mm Hg (or $\geq 130/80$ mm Hg for individuals with chronic kidney disease or diabetes): • As tolerated, add blood pressure medication, treating initially with β-blockers and/or ACE inhibitors, with addition of other drugs such as thiazides as needed to achieve goal blood pressure. I (A) • [For compelling indications for individual drug classes in specific vascular diseases, see Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7).]⁴

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	Intervention Recommendations With Class of Recommendation and Level of Evidence
LIPID MANAGEMENT:	For all patients:
Goal LDL-C <100 mg/dL If triglycerides are \geq 200 mg/dL, non-HDL-C should be <130 mg/dL [†]	<ul style="list-style-type: none"> • Start dietary therapy. Reduce intake of saturated fats (to <7% of total calories), <i>trans</i>-fatty acids, and cholesterol (to <200 mg/d). I (B) • Adding plant stanol/sterols (2 g/d) and viscous fiber (>10 g/d) will further lower LDL-C. • Promote daily physical activity and weight management. I (B) • Encourage increased consumption of omega-3 fatty acids in the form of fish[‡] or in capsule form (1 g/d) for risk reduction. For treatment of elevated triglycerides, higher doses are usually necessary for risk reduction. Iib (B)
	For lipid management:
	<p>Assess fasting lipid profile in all patients, and within 24 hours of hospitalization for those with an acute cardiovascular or coronary event. For hospitalized patients, initiate lipid-lowering medication as recommended below before discharge according to the following schedule:</p> <ul style="list-style-type: none"> • LDL-C should be <100 mg/dL I (A), and • Further reduction of LDL-C to <70 mg/dL is reasonable. Iia (A) • If baseline LDL-C is \geq 100 mg/dL, initiate LDL-lowering drug therapy.[§] I (A) • If on-treatment LDL-C is \geq 100 mg/dL, intensify LDL-lowering drug therapy (may require LDL-lowering drug combination). I (A) • If baseline LDL-C is 70 to 100 mg/dL, it is reasonable to treat to LDL-C <70 mg/dL. Iia (B) • If triglycerides are 200 to 499 mg/dL, non-HDL-C should be <130 mg/dL. I (B), and • Further reduction of non-HDL-C to <100 mg/dL is reasonable. Iia (B) <p>Therapeutic options to reduce non-HDL-C are:</p> <ul style="list-style-type: none"> • More intense LDL-C-lowering therapy I (B), or • Niacin[¶] (after LDL-C-lowering therapy) Iia (B), or • Fibrate therapy[#] (after LDL-C-lowering therapy) Iia (B) <p>If triglycerides are \geq 500 mg/dL[#], therapeutic options to prevent pancreatitis are fibrate[¶] or niacin[¶] before LDL-lowering therapy; and treat LDL-C to goal after triglyceride-lowering therapy. Achieve non-HDL-C <130 mg/dL if possible. I (C)</p>
PHYSICAL ACTIVITY:	For all patients , assess risk with a physical activity history and/or an exercise test, to guide prescription. I (B)
Goal 30 minutes, 7 days per week (minimum 5 days per week)	<ul style="list-style-type: none"> • For all patients, encourage 30 to 60 minutes of moderate-intensity aerobic activity, such as brisk walking, on most, preferably all, days of the week, supplemented by an increase in daily lifestyle activities (e.g., walking breaks at work, gardening, and household work). I (B) • Encourage resistance training 2 days per week. Iib (C) • Advise medically supervised programs for high-risk patients (e.g., recent acute coronary syndrome or revascularization, heart failure). I (B)
WEIGHT MANAGEMENT:	<ul style="list-style-type: none"> • Assess body mass index and/or waist circumference on each visit and consistently encourage weight maintenance/reduction through an appropriate balance of physical activity, caloric intake, and formal behavioral programs when indicated to maintain/achieve a body mass index between 18.5 and 24.9 kg/m². I (B) • If waist circumference (measured horizontally at the iliac crest) is \geq 35 inches in women and \geq 40 inches in men, initiate lifestyle changes and consider treatment strategies for metabolic syndrome as indicated. I (B) • The initial goal of weight loss therapy should be to reduce body weight by approximately 10% from baseline. With success, further weight loss can be attempted if indicated through further assessment. I (B)
Goal Body mass index: 18.5 to 24.9 kg/m ² Waist circumference: men <40 inches, women <35 inches	

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DIABETES MANAGEMENT: Goal HbA1C <7%	<ul style="list-style-type: none"> • Initiate lifestyle and pharmacotherapy to achieve near-normal HbA1C. I (B) • Begin vigorous modification of other risk factors (e.g., physical activity, weight management, blood pressure control, and cholesterol management as recommended above). I (B) • Coordinate diabetic care with patient’s primary care (practitioner) or endocrinologist. I (C)
ANTIPLATELET AGENTS/ ANTICOAGULANTS:	<ul style="list-style-type: none"> • Start aspirin 75 to 162 mg/d and continue indefinitely in all patients unless contraindicated. I (A) <ul style="list-style-type: none"> ➢ For patients undergoing coronary artery bypass grafting, aspirin should be started within 48 hours after surgery to reduce saphenous vein graft closure. Dosing regimens ranging from 100 to 325 mg/d appear to be efficacious. Doses higher than 162 mg/d can be continued for up to 1 year. I (B) • Start and continue clopidogrel 75 mg/d in combination with aspirin for up to 12 months in patients after acute coronary syndrome or percutaneous coronary intervention with stent placement (≥ 1 month for bare metal stent, ≥ 3 months for sirolimus-eluting stent, and ≥ 6 months for paclitaxel-eluting stent). I (B) <ul style="list-style-type: none"> ➢ Patients who have undergone percutaneous coronary intervention with stent placement should initially receive higher-dose aspirin at 325 mg/d for 1 month for bare metal stent, 3 months for sirolimus-eluting stent, and 6 months for paclitaxel-eluting stent. I (B) • Manage warfarin to international normalized ratio=2.0 to 3.0 for paroxysmal or chronic atrial fibrillation or flutter, and in post–myocardial infarction patients when clinically indicated (e.g., atrial fibrillation, left ventricular thrombus). I (A) • Use of warfarin in conjunction with aspirin and/or clopidogrel is associated with increased risk of bleeding and should be monitored closely. I (B)
RENIN-ANGIOTENSIN- ALDOSTERONE SYSTEM BLOCKERS:	<p>ACE inhibitors:</p> <ul style="list-style-type: none"> • Start and continue indefinitely in all patients with left ventricular ejection fraction $\leq 40\%$ and in those with hypertension, diabetes, or chronic kidney disease, unless contraindicated. I (A) • Consider for all other patients. I (B) • Among lower-risk patients with normal left ventricular ejection fraction in whom cardiovascular risk factors are well controlled and revascularization has been performed, use of ACE inhibitors may be considered optional. IIa (B) <p>Angiotensin receptor blockers:</p> <ul style="list-style-type: none"> • Use in patients who are intolerant of ACE inhibitors and have heart failure or have had a myocardial infarction with left ventricular ejection fraction $\leq 40\%$. I (A) • Consider in other patients who are ACE inhibitor intolerant. I (B) • Consider use in combination with ACE inhibitors in systolic-dysfunction heart failure. IIb (B) <p>Aldosterone blockade:</p> <ul style="list-style-type: none"> • Use in post–myocardial infarction patients, without significant renal dysfunction** or hyperkalemia††, who are already receiving therapeutic doses of an ACE inhibitor and β-blocker, have a left ventricular ejection fraction $\leq 40\%$, and have either diabetes or heart failure. I (A)
β-BLOCKERS:	<ul style="list-style-type: none"> • Start and continue indefinitely in all patients who have had myocardial infarction, acute coronary syndrome, or left ventricular dysfunction with or without heart failure symptoms, unless contraindicated. I (A) • Consider chronic therapy for all other patients with coronary or other vascular disease or diabetes unless contraindicated. IIa (C)

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	Intervention Recommendations With Class of Recommendation and Level of Evidence
INFLUENZA VACCINATION:	Patients with cardiovascular disease should have an influenza vaccination. I (B)
<p>*Patients covered by these guidelines include those with established coronary and other atherosclerotic vascular disease, including peripheral arterial disease, atherosclerotic aortic disease, and carotid artery disease. Treatment of patients whose only manifestation of cardiovascular risk is diabetes will be the topic of a separate AHA scientific statement. ACE indicates angiotensin-converting enzyme.</p> <p>[†]Non-HDL-C= total cholesterol minus HDL-C.</p> <p>[‡]Pregnant and lactating women should limit their intake of fish to minimize exposure to methylmercury.</p> <p>[§]When LDL-lowering medications are used, obtain at least a 30% to 40% reduction in LDL-C levels. If LDL-C <70 mg/dL is the chosen target, consider drug titration to achieve this level to minimize side effects and cost. When LDL-C <70 mg/dL is not achievable because of high baseline LDL-C levels, it generally is possible to achieve reductions of >50% in LDL-C levels by either statins or LDL-C-lowering drug combinations.</p> <p>Standard dose of statin with ezetimibe, bile acid sequestrant, or niacin.</p> <p>[¶]The combination of high-dose statin+fibrate can increase risk for severe myopathy. Statin doses should be kept relatively low with this combination. Dietary supplement niacin must not be used as a substitute for prescription niacin.</p> <p>[#]Patients with very high triglycerides should not consume alcohol. The use of bile acid sequestrant is relatively contraindicated when triglycerides are >200 mg/dL.</p> <p>**Creatinine should be <2.5 mg/dL in men and <2.0 mg/dL in women.</p> <p>^{††}Potassium should be <5.0 mEq/L.</p>	

TABLE 2. Classification of Recommendations and Level of Evidence*

Classification of Recommendations
Class I: Conditions for which there is evidence and/or general agreement that a given procedure or treatment is beneficial, useful, and effective.
Class II: Conditions for which there is conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of a procedure or treatment.
Class IIa: Weight of evidence/opinion is in favor of usefulness/efficacy.
Class IIb: Usefulness/efficacy is less well established by evidence/opinion.
Class III: Conditions for which there is evidence and/or general agreement that a procedure/treatment is not useful/effective and in some cases may be harmful.
Level of Evidence
Level of Evidence A: Data derived from multiple randomized clinical trials or meta-analyses.
Level of Evidence B: Data derived from single randomized trial or nonrandomized studies.
Level of Evidence C: Only consensus opinion of experts, case studies, or standard-of-care.
*Classification of Recommendations and Level of Evidence are expressed in the ACC/AHA format and described in more detail in Table 3.

Measurement of Efficacy of the Clinical Practice Guideline

Two elements are measured to gauge the efficacy of the practitioner’s compliance with the Clinical Practice Guideline.

These two measures are:

1) HEDIS® Measure:

Clinical Practice Guideline (CPG)	HEDIS® Measure	Measure
CPG Secondary Prevention for Patients with Coronary and Other Vascular Disease	Cholesterol Management for Patients with Cardiovascular Conditions	LDL-C Screening

2) HEDIS® Measure:

Clinical Practice Guideline (CPG)	HEDIS® Measure	Measure
CPG Secondary Prevention for Patients with Coronary and Other Vascular Disease	Cholesterol Management for Patients with Cardiovascular Conditions	LDL-C < 100

NOTE about LDL Level after a Myocardial Infarction:

Clinicians should be measuring LDL cholesterol and C-reactive protein levels in patients following myocardial infarction. Recent evidence has revealed that use of statin therapy following hospitalization for AMI reduces long-term risks. A sub-study from the PROVE-IT trial has demonstrated that the achievement of an LDL less than 70 and C-reactive protein (CRP) less than 2 mg/l around 30 days following hospitalization was associated with the lowest risk of recurrent clinical events by two years of follow-up. The achievement of these goals was more important than the selection of an individual statin agent. This evidence supports the measurement of LDL cholesterol and C-reactive protein levels about one month following hospital discharge and the aggressive use of statin therapy to achieve an LDL less than 70 mg/dl and a CRP of less than 2 mg/l by that time frame. Some patients may achieve these values through moderate statin doses, most will require higher doses of potent statins, and some patients will require combination therapy with a statin plus ezetimibe. Of interest, achievement of either goal alone (LDL less than 70 or CRP less than 2) but not both was associated with significantly higher recurrence risks.¹

Reference

1. Institute for Clinical Systems Improvement (ICSI). Diagnosis and treatment of chest pain and acute coronary syndrome (ACS). Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2006 Oct. 76 p. [121 references]